



EMPLOYER APPLICATION FOR DENTAL PLAN PARTICIPATION

EMPLOYER INFORMATION			
Legal Name of Employer	Federal Tax ID No.	Effective Date	Anniversary Date
Are you a current member of AOI Yes No		AOI Membership Number:	
Name and Title of person responsible for benefit decisions		Phone No. ()	Fax No. ()
Address _____		# of Eligible Employees	Total # of Employees
Street _____		Nature of Business	SIC code
City	State		
E-mail and/or website address:			
SELECTION OF DENTAL BENEFITS			
DENTAL COVERAGE			
Please select a benefit level: (Note: If your company has not had 24 months of prior dental coverage, you must choose the Value Plan. Please provide proof of prior dental coverage upon submission of enrollment materials.)			
Preferred Plan		Standard Plan	
Value Plan			
Name of prior carrier _____			Prior Carrier Group # _____
Most recent prior coverage begin date _____ end date _____			
CURRENT COVERAGE			
Prior to enrolling in AOI HealthChoice, what type of dental coverage was in effect? (check all that apply)			
No prior coverage Insured	Self-Insured Indemnity	DHMO Other: _____	PPO

EMPLOYER CONTRIBUTION	
AOI HealthChoice requires a minimum employer contribution of 100% of the Employee Only rate for the benefit plan chosen.	
Amount to be paid by Employer:	
For Employee Only Coverage	_____ % or \$ _____
For Employee + Spouse Coverage	_____ % or \$ _____
For Employee + Child(ren) Coverage	_____ % or \$ _____
For Employee + Family Coverage	_____ % or \$ _____

WAITING PERIOD	COBRA ADMINISTRATION
AOI HealthChoice allows employers the opportunity to determine waiting period. Select One: Coverage will become effective on the 1st day of the month following: _____ Date of Hire _____ 60 days After Date of Hire _____ 30 days After Date of Hire _____ 90 days After Date of Hire Note: If you have more than one class of eligible employees and want to select different waiting periods for each class, please check here and describe at the bottom of this form. <input type="checkbox"/>	Employers with 20 or more employees may elect to have AOI HealthChoice administer COBRA for eligible employees/dependents. If you are an employer with 20 or more full or part time employees, would you like AOI HealthChoice Administrators to administer COBRA for eligible employees/dependents? <div style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> If yes, please indicate the total number of employees in your company _____

BILLING INFORMATION	
Name and title of person responsible for billing and accounting	Phone No. ()
Address (if different from above)	
Street	
City	State Zip Code County

INSURANCE PROFESSIONAL INFORMATION (Broker/Agent)					
I hereby designate the following as my insurance professional (Broker/Agent) of record as of the initial effective date of coverage under AOI HealthChoice plans.					
Name			Name of Firm		
Address	City	State	Zip Code	Phone No. ()	Fax No. ()
Please indicate to whom commissions should be made payable:					
E-mail address:					

AUTHORIZATION
I certify, to the best of my knowledge, the information reported above is true and accurate. I further certify that I have read and comply with AOI HealthChoice Participation Policies. Employer Representative Signature/Title _____ Date _____ <i>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.</i>

NOTE: There is a \$15.00 monthly administration charge for groups enrolling in the dental-only plans. This amount will appear on your monthly invoice.