



MASTER APPLICATION

COMPANY INFORMATION			
Exact Legal Name of Company:		Requested Start Date:	
Street Address	City	State	Zip Code
Shipping or Mailing Address <i>(If different from above):</i>	City	State	Zip Code
Group Contact:	Phone: ()	Fax: ()	
	Email :		
Type of Business <i>(please provide as much detail as possible):</i>			Yrs. In Business:
Prior Dental Insurance Carrier:		Group Tax ID Number:	
Employer Contributions Levels: Employee _____% Dependents _____%		Billing Options: <input type="checkbox"/> HOURLY (eligibility hours _____) <input type="checkbox"/> MONTHLY	
DENTAL PLAN			
<input type="checkbox"/> DeltaCare Plan 10B			
<input type="checkbox"/> DPO Option USA* (minimum of 3 lives required) *12 month wait for Major work waived for new groups. New hires are subject to 12 month wait.			
BROKER / GENERAL AGENCY INFORMATION			
Broker Name:		Email:	
Agency Name:		Tax ID: (commission will be reported under this number)	
Address:		Phone:	Fax:
AUTHORIZATION			
Print or Type Name		Title	
Signature		Date	