



# NEW YORK APPLICATION FOR EMPLOYER DENTAL BENEFITS POLICY

Horizon Healthcare  
Dental Programs  
3 Penn Plaza East PP03K  
Newark, NJ 07105-2200  
1-888-667-4547

Please print or type  New Policy  Change in Policy Policy No. \_\_\_\_\_ Requested Effective Date \_\_\_\_\_

## SECTION 1: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): \_\_\_\_\_

2. Tax Identification Number: 

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3. Main Address: \_\_\_\_\_  
STREET CITY STATE ZIP CODE COUNTY

Mailing Address (Billing): \_\_\_\_\_  
STREET CITY STATE ZIP CODE

Telephone: 

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 Facsimile: 

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4. Name of Company Official: \_\_\_\_\_ Title: \_\_\_\_\_

5. Type of Organization:  Corporation  Partnership  Proprietorship  Other (explain): \_\_\_\_\_

6. Nature of Business (specify): \_\_\_\_\_ SIC Code: \_\_\_\_\_

7. Number of eligible employees in your company: \_\_\_\_\_ 8. Number of eligible employees to be insured: \_\_\_\_\_  
*(Eligible employees are those who work at least 25 hrs. per week)*

9. Class or classes to be excluded: \_\_\_\_\_

10. Insurance requested for:  Employees Only  Employees and Dependents

11. Are you subject to the requirements of COBRA?  Yes  No

12. Waiting period before new/rehired employees become insured: (may not exceed 6 months) Present: \_\_\_\_\_ New: \_\_\_\_\_

13. What percentage of the premium will the employer pay? \_\_\_\_\_ 14. Deposit \$ \_\_\_\_\_

Premium Paid:  Monthly  Quarterly  Automatic checking withdrawal

**The premium for the first month of coverage must be attached.**

Premium will be due as of the effective date.

## SECTION 2: SPECIFICATION OF COVERAGE (Dental Benefits Selection)

- |   |   |
|---|---|
| 1. <input type="checkbox"/> Horizon Dental Option | 3. <input type="checkbox"/> Horizon Dental PPO Access |
| 2. <input type="checkbox"/> Horizon Dental PPO    | 4. <input type="checkbox"/> Other                     |

## SECTION 3: PLAN

**Horizon Healthcare Insurance Company of New York**

## SECTION 4: ALL QUESTIONS MUST BE ANSWERED

a. Name of present or prior group carrier \_\_\_\_\_

Effective date of prior coverage \_\_\_\_\_ Cancellation/Termination Date \_\_\_\_\_

Is the coverage applied for in this application replacing other group insurance?  Yes  No

If "Yes", give reason \_\_\_\_\_

Please attach copy of the prior carrier bill received in last 90 days.

b. Has your firm been uninsured for 3 or more months prior to application?  Yes  No

## SECTION 5: SIGNATURE

It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of any of the companies identified in Section 3 ("Horizon Healthcare") to make or modify any request or application for insurance or to bind Horizon Healthcare by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Horizon Healthcare. No contract of insurance is to be implied in any way on the basis of the completion and or submission of this application.

Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be subject to criminal and civil penalties.

\_\_\_\_\_  
Print name of Officer, Partner, or Owner

\_\_\_\_\_  
Signature of Officer, Partner, or Owner

\_\_\_\_\_  
Witness to Signature

\_\_\_\_\_  
Dated at \_\_\_\_\_ on \_\_\_\_\_

**Note:** If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

**FRAUD WARNING:** Any person who knowingly and with intent to fraud 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**AGENT/PRODUCER INFORMATION (THIS INFORMATION MUST BE ANSWERED COMPLETELY)**

_____	_____	_____
BROKER SIGNATURE	DATE	VENDOR NUMBER
BROKER-NAME	NAME OF AGENCY	TELEPHONE NUMBER
STREET	CITY	STATE      ZIP CODE
OTHERS (NAME, TITLE)		
SPECIAL INSTRUCTIONS		

**FOR INTERNAL GROUP DENTAL ENROLLMENT USE**

Coverage Code	c/o														
TOTAL APPLICATIONS SUBMITTED															
TRANSFER FROM GROUP # _____															
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)															
EMPLOYER CONTRIBUTION															
EFFECTIVE DATE															
FUTURE RATE RENEWAL DATE															
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