



Delta Dental Davis Vision Plan

Employer Application

	<input type="checkbox"/> DENTAL COVERAGE	<input type="checkbox"/> VISION COVERAGE
Applying For:	<input type="checkbox"/> DeltaCare DC I	<input type="checkbox"/> DPO Emerald 10
	<input type="checkbox"/> DeltaCare DC II	<input type="checkbox"/> DPO Diamond 15
	<input type="checkbox"/> DeltaCare DC III	
		<input type="checkbox"/> Designer <input type="checkbox"/> Premier

Enrollment Acknowledgement

Firm Name: _____ (_____) _____
 Phone

Street Address: _____ City _____ State _____ Zip _____ E-mail Address _____

Exact Nature of Business _____ SIC Code _____ In Business Since _____ Whom do we contact at the firm for information? _____

I certify that I have read the Program provisions and highlight sections, understand them, and have enrolled all eligible employees and their dependents in accordance with the program's requirements. I have discussed coverages, eligibility, and expenses not covered with my broker and understand them fully.

I certify that this is a bona fide business with a legitimate business purpose and that a true employer-employee relationship exists with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date, and denial of all claims incurred. A DE-6 (California State Quarterly Wage Report) form, for groups of fewer than 10 employees, for the most current quarter is enclosed, and if requested, future DE-6 filings will be provided.

EMPLOYER CONTRIBUTIONS – All eligible employees working 24 or more hours per week must enroll for coverage (or as mirrors the eligibility under your medical plan), unless they have other group dental/vision coverage in effect. To encourage continuing employee participation, the Employer must pay 100% of the employee cost. Employer Contribution for Dependent Coverage is: under 50% over 50%.

Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the Program; (2) the date the Master Group Dental Service and/or Master Group Vision Contract is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium. The benefits are subject to all conditions and limitations of the Program.

Classes of Employees Not Eligible _____

Total No. Of Employees on Payroll _____ Total No. Of Full-Time Employees on Payroll _____ Employer's Federal Taxpayer ID Number _____ Requested Effective Date (Must be 1st of the month subject to approval) _____

Dated _____ Month _____ Day _____ Year _____ By: _____ Signature of Company Officer

Administered By:

PacFed Benefit Administrators, Inc.
1000 N. Central Avenue, Suite 400
Glendale, California 91202
(800) 308-5443

Print Name

