Application for Group Dental Coverage
Willamette Dental of Idaho, Inc.

Please type or print REQUESTED EFFECTIVE DATE____________________________

Applicant

Full Legal Name of Group (exactly as it is to be shown in the contract)

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Street Address____

City_______________________________ State_______________Zip Code___________________________

Phone Number ( )_____________________ FAX Number ( )___________________________________

Group Contact_______________________ Contact's Title_______________________________________

Contact's Phone No. *if different* ( )__________ Contact's FAX *if different* ( )_________________________

Type of Business____

DENTAL COVERAGE REQUESTED

[ ] Employee only [ ]Employee & Dep(s) [ ] Retiree Only [ ] Retiree & Dep [ ] Domestic Partners

OTHER INSURANCE

A. Does this coverage supplement other insurance? [ ] Yes [ ] No

B. Does this coverage replace existing insurance? [ ] Yes [ ] No
*If yes, please submit a copy of each in force contract, certificate or plan document.

Effective date of Prior Plan_______________ Termination date of Prior Plan_______________

APPLICANT AGREES THAT: **I hereby apply for Group Dental Coverage as provided in the attached proposal.**
The above information is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group dental coverage.
If the requested coverage is acceptable to Willamette Dental of Idaho, Inc. under its current rules and practices and is legally permissible, a group contract will be issued in the language customarily used by Willamette Dental of Idaho, Inc. It will be effective on the date determined by Columbia Dental of Idaho, Inc. No agent or broker has the authority to guarantee the acceptability of the requested coverage.
The coverage if approved, will be subject to Willamette Dental of Idaho Inc.'s usual underwriting requirements, including the exclusions and limitations in the group contract.
No material describing coverage under the group contract will be distributed by the Applicant to any person to be covered without prior written consent of Willamette Dental of Idaho, Inc.
Premium rate quotations were based on data submitted to Willamette Dental of Idaho, Inc. Final premium rates will be determined by the actual composition of the group.
The consideration for any group contract which may be issued is this Application and the payment of premiums. Payment of premium after receipt of the group contract is acceptance of the terms of the group contract.
This application, including the attached proposal, is made a part of the group contract.

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Signature and Title of Applicant's Authorized Representative

Signature of Witness Signature of Licensed Agent (where required by law)

Date License #
(Must be signed prior to the requested effective date.)