Group Enrollment Application

Plan Selection

Groups may select up to two different LIBERTY DHMO Plans in the same group when a minimum of two employees are enrolled in each plan. Select benefit plans and premium rates on selection that applies.

LIBERTY Online Portal

If the Group is interested in using the online group administrative portal, please check the following box and we can contact you with more information.

☐ Yes, I am interested in receiving more information regarding LIBERTY's online group portal.

Premium Payment

Group shall pay monthly Premiums to LIBERTY in accordance with the Premium rates set forth in the Group Application.

- Billing will occur around the 5th of each month.
- Premium is due by the 20th prior to month of coverage.
- Payments received after the 10th of the coverage month will be considered late.

Group shall remit such Premium payments in the form of a check or money order to:

LIBERTY Dental Plan
File 1751
1801 W. Olympic Blvd
Pasadena, CA 91199-1751

Wire/ACH Payment setup is available upon request.

Late Enrollment Notice

New cases are to be received by the 20th of the month, prior to the group's effective date for timely processing.

New groups received after the 20th of the month, for eligibility beginning the first of the following month, will be accepted only if the employer pays two months of premium, no later than the 10th of the month of eligibility.

- Employer understands that if dentist is not selected upon initial enrollment, dentist will be auto-assigned by ZIP code.
- Employer understands ID cards will arrive after the first of the month's effective date.
- Employer will advise employees to contact LIBERTY Member Services at **888.703.6999** for confirmation of eligibility prior to scheduling their first appointment, unless they have already received their ID Card from LIBERTY.

Send completed application to your Word & Brown Sales Representative.

LIBERTY Dental Plan of California, Inc.
Application for Group Dental Coverage

Effective Date: _____ Rate Guarantee: ☐ 12 months ☐ 24 months ☐ Other: _____

Company Corporate Information

Full Legal Name: _____

DBA (if different): _____

Street Address: _____ City: _____

State: _____ Zip: _____ Prior Carrier: _____

Company Contact Information

Main Contact: _____ Telephone: _____

Email: _____ Fax: _____

Billing Contact (if different): _____ Telephone: _____

Email: _____ Fax: _____

Eligibility Contact (if different): _____Telephone: _____

Email: _____ Fax: _____

Third-Party Administration

If the Company uses a TPA, complete information below.

Administrator's Name: _____

Contact Person: _____Telephone: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

COBRA Administration

If the Company uses a COBRA Administrator, complete information below.

Administrator's Name: _____

Contact Person: _____Telephone: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

The Company allows LIBERTY to have direct contact with the following administrator. Check all that apply.

☐ COBRA Administrator ☐ TPA ☐ No direct contact allowed ☐ Not applicable

LIBERTY Dental Plan of California, Inc.
Application for Group Dental Coverage

Benefit Plan(s) & Premium Rates

Plan Name: _____

☐ 1-Tier ☐ 3-Tier ☐ 4-Tier

Composite $_____
EE = $_____
EE+1 = $_____
FM = $_____
EE = $_____
ES = $_____
EC = $_____
FM = $_____

Plan Name: _____

☐ 1-Tier ☐ 3-Tier ☐ 4-Tier

Composite $_____
EE = $_____
EE+1 = $_____
FM = $_____
EE = $_____
ES = $_____
EC = $_____
FM = $_____

Dependent Maximum Age Is 26.

Group Setup Information

Do you require individual sub-groups? Check all that apply.

☐ N/A ☐ Retirees ☐ COBRA ☐ Other *: _____

*Please provide employee type and brief explanation of why a sub-group is needed.

Agent/Broker Information

Agent/Broker Name: _____

Agent/Broker Company Name: _____

License Number: _____ LDP Agent Number (if appointed): _____

General Agency: _____

Signatures

The undersigned acknowledge that all statements and answers given in this application are accurate and complete. The undersigned further acknowledge that completion and submission of this application does not guarantee acceptance into LIBERTY's Group Dental Plan.

Applicant (Company)

_____ Print Name

_____ Title

_____ Signature

_____ Date

Agent/Broker

_____ Print Name

_____ Title

_____ Signature

_____ Date