



ENROLLMENT APPLICATION – EMPLOYER GROUP
ALL ITEMS ARE REQUIRED – Available in Paper, MS Word and HRI Web Site

EMPLOYER GROUP

Legal Business Name:		Tax ID:
Service Type: <input type="checkbox"/> Non-ASO-Full Services – Fully Insured <input type="checkbox"/> ASO-Administrative Services – Self Insured	State & County:	Primary Business:
HRI Use:		

DENTAL HEALTH OPTION

DHO Plan	Ortho Rider	Tier Description	Pricing	No. Enrolled	Employer Contribution (% or \$)
DHO: _____ Annual Max: \$ _____	<input type="checkbox"/> A- Adult & Dep <input type="checkbox"/> B- Dep Only Lifetime Max: \$ _____	<input type="checkbox"/> Tier #	\$		
		<input type="checkbox"/> Tier #	\$		
		<input type="checkbox"/> Tier #	\$		
		<input type="checkbox"/> Tier #	\$		
		Total Number of Tiers:	Check Total: \$	Total Enrolled:	<input type="checkbox"/> No contribution, plan is voluntary

PLAN ADMINISTRATION

Enrollment Membership Card Distribution		
BA Binder (select one) <input type="checkbox"/> Benefits Administrator <input type="checkbox"/> Agent	First Set of Cards (select one) <input type="checkbox"/> Benefits Administrator <input type="checkbox"/> Subscriber <input type="checkbox"/> Agent	Future Cards (select one) <input type="checkbox"/> Benefits Administrator <input type="checkbox"/> Subscriber
Effective Date Always 1 st of Month Month: _____ Year: _____	Waiting Period for Employees When are the employees effective at time of contract: <input type="checkbox"/> Immediately or <input type="checkbox"/> Waiting Period for Future Employees Waiting Period for Future Employees: <input type="checkbox"/> 1st of month following _____ days employed OR _____ months employed <input type="checkbox"/> Other – Explain: _____ <input type="checkbox"/> Rehire Policy: _____	Section 125 Plan Plan <input type="checkbox"/> Yes Plan Year Month Start: _____ Month End: _____
Termination <input type="checkbox"/> End of month <input type="checkbox"/> Date of termination <input type="checkbox"/> Other _____ HRI will credit up to 30 days retroactively from submission if no claims have been paid. If a group is subject to COBRA, immediate notification is required to HRI.	COBRA Response required if 20+ Emp. Employer Administered <input type="checkbox"/> Yes by the Employer <input type="checkbox"/> Yes by a Third Party <input type="checkbox"/> No Explain: _____ HRI Administered <input type="checkbox"/> No <input type="checkbox"/> Yes Fee \$_____ per month <input type="checkbox"/> Fee included in Rate <input type="checkbox"/> Fee billed Separately	Dependent Coverage Maximum Age: _____ <input type="checkbox"/> Covered to end of month <input type="checkbox"/> Covered to end of year Full Time Student Age: _____ <input type="checkbox"/> Covered to end of month <input type="checkbox"/> Covered to end of year

EMPLOYER GROUP CONTACTS

Contact	Employer Benefits Administrator	Employer Invoicing	Employer IT
Name			
Phone Number			
Fax Number			
Email			
Street Address			
City			
State, Zip Code			

REPRESENTATIVE CONTACTS

	Agent Information	Agency Information	HRI Regional Sales Manager
Name			
Phone Number			
Email/Web Site			
Street Address			
City			
State, Zip Code			
County/HRI Region			
Comm. % Assigned			

AGREEMENT AND SIGNATURES

It is agreed the dental health option applied for shall not become effective unless Health Resources, Inc. approves the application. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Representatives	Signature and Print Name	Title	Date
Employer Group			
Agent			
HRI Sales Manager			
HRI Approval			