

Select a Dental Plan

Please print neatly or type.

Company Information						
Company's Legal Name	DBA (if applicable)			Application Date		
Address 1						
Address 2						
City	State	County	ZIP Code			
Telephone Number	Fax Number					
Primary Authorized Representative	E-Mail Address of Representative					
Employer Identification Number (Tax ID)	Nature of Business	Industry SIC Code				
Billing Contact Information (if different from above)						
Billing Contact Name	E-Mail Address of Contact					
Address 1						
Address 2						
City	State	ZIP Code				
Telephone Number	Fax Number					
Dental Plan Participation and Dental Contract Information						
UPMC Dental <i>Advantage</i> Effective Date (1st of month)	mm/dd/yyyy	Prior Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No			
		Name of Prior Carrier				
Dependent Age Limits	Rates and Contributions					
Participation Summary _____ # Eligible Employees _____ # Enrolled _____ # Waived _____ # Dependents	Tier Structure	Number of Enrolled Employees	Total Dental Rate	Employer Contribution %	Employee Contribution %	
	Single		\$			
UPMC Health Plan administers benefit plans underwritten by UPMC Health Benefits, Inc.	Family		\$			
Signature Section						

Note: I, the authorized representative of the Employer and Policyholder, understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application before UPMC Health Plan will take action on this Application.

I understand and agree that the initial term of this Policy is one (1) year, unless terminated earlier in accordance with the provisions stipulated in the Employer Group Agreement, Article 6. An Employer may terminate its policy, effective as of the date that the revised premium rates (Renewal Date) would become effective, by providing written notice to UPMC Health Plan of its intent to terminate. Such notice shall be given within thirty (30) days prior to the effective date of the proposed renewal rate change.

I further acknowledge that failure to pay premium when due will be considered a default in premium payment, and that the Group will terminate coverage following a grace period of thirty (30) days that starts on the first day after the premium payment is due. Termination of the Agreement following the expiration of the Grace Period shall not relieve a Group of its obligation to make payment of premiums for coverage provided through the Grace Period.

As an authorized representative of this Employer, I have reviewed and do hereby agree to the terms and conditions stated herein and in the policy forms. I further attest and certify that all of the statements included herein are true and correct to the best of my knowledge. I understand that material omissions or misrepresentations could adversely affect coverage, including, but not limited to, termination of coverage.

Any person who knowingly and with intent to defraud 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 subjects such person to criminal and civil penalties.

Authorized Officer's Name _____ Title _____

Authorized Officer's Signature _____ Date _____

The term UPMC Health Plan collectively refers to UPMC Health Plan, Inc., UPMC Health Benefits, Inc., and UPMC Dental *Advantage*.