American Dental Plan of Wisconsin, Inc.

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APPLICATION FOR MASTER GROUP CONTRACT

MASTER GROUP CONTRACT# _____

BENEFIT CONTRACT DESCRIPTION _____

The Enrolling Unit named below hereby makes application to American Dental Plan of Wisconsin, Inc. for a Master Group Contract to be issued in accordance with the specifications of this application.

1. **Name of Enrolling Unit:** _____

2. **Address:** _____
(Number and Street) (City) (State) (Zip) (County)

Billing Address (if different from above): Telephone Number: _____

_____
(Number and Street) (City) (State) (Zip)

3. **Legal Status:** ☐Corporation ☐Partnership ☐Proprietorship ☐Trust

☐Other (specify) _____ Employer Taxpayer Identification Number_____

4. **Nature of Business or Industry:** _____

5. **Subsidiaries:** The following subsidiaries, affiliates or other related organizations will be included under the Master Group Contract:

_____

6. **Definition of Eligible Persons and Dependents:**

Eligible Employee (as defined in MGC): _____

_____

Eligible Dependents (as defined in MGC): _____

Excluded Employees: _____

7. **Open Enrollment Period:** The open enrollment period for this contract year will begin

on _____ and end on _____

8. **Initial Eligibility Period:** (Probationary Period) Individuals who are not eligible on the date the Master Group Contract takes effect, and who otherwise become eligible according to the requirements specified in the Master Group Contract, will be eligible for enrollment:

_____

_____

9. **Effective Date:** The Master Group Contract will be delivered in and governed by the laws of the State of Wisconsin and shall take effect

on _____ but only if the following conditions are satisfied: (a) this Application is accepted and signed by ADP of WI, Inc.; and (b) at least _____ Eligible Persons have enrolled for coverage if dual or multiple choice.

Annual Renewal Date shall be _____

The Dental Services Fees specified on this application are guaranteed until _____

10. **Dental Services Fee:** All Dental Services Fees shall be paid by the Enrolling Unit to ADP of WI, Inc. at is Madison Office on or before the 25th of the month preceding the first month of coverage.

11. **Riders/Endorsements to Group Master Contract:**

Employee/s and/or dependent/s may not disenroll until the contract anniversary date (unless employment is terminated or the dependent is no longer a dependent).

All employees must be enrolled in a health insurance plan to be eligible for ADP of WI, Inc. coverage either through their employer or his/her spouse's employment.

EMPLOYEES VOLUNTARILY TERMINATING MAY NOT RE-ENROLL FOR A PERIOD OF TWO YEARS.

12. **Dental Services Fee Contributions:** The Enrolling Unit and Enrollees will initially contribute toward the cost of the monthly Dental Services Fee as specified below:

	DENTAL SERVICES FEE	(EMPLOYER) ENROLLING UNIT CONTRIBUTION	ENROLLEE CONTRIBUTION
CLASS I - EMPLOYEE ONLY			
CLASS II - EMPLOYEE, ONE DEPENDENT			
CLASS III -			
CLASS IV - EMPLOYEE AND ONE OR MORE DEPENDENTS			
ADMINISTRATIVE FEE:			

13. **Please name the Group Administrator of your dental benefits plan:** _____

Phone Number _____ Title _____

The Enrolling Unit hereby agrees and understands that the Master Group Contract issued is based on this application and that the acceptance of the Master Group Contract constitutes aggreement to all terms and conditions of this Application and the Master Group Contract. A copy of this application shall be attached to and made a part of the Master Group Contract issued to the Enrolling Unit.

Signed at _____ on the _____ of _____
Address of Enrolled Unit Day Month Year

FOR THE ENROLLING UNIT:

By _____ Title _____
Executive of Enrolling Unit

FOR THE AMERICAN DENTAL PLAN OF WISCONSIN, INC..

By _____ Title _____

FIELD UNDERWRITER:

By _____ Agency: _____ Date: _____

FOR AMERICAN DENTAL PLAN OF WISCONSIN, INC. OFFICE USE ONLY

☐Approved ☐Disapproved By _____

Master Group Contract Number _____ Date _____ Addendum Attached _____