

Group Business  
**Group Application**

**The Harbor Dental Plan is NOT health insurance. This discount card program contains a 30 day cancellation period.** The plan provides discounts at certain providers for dental services. The plan does not make payments directly to the providers of dental services. The plan member is obligated to pay for all services rendered but will receive a discount from those providers who have contracted with **Harbor Dental Plan, L.P.** Discount Medical Plan Organization: Newbn, Inc. 14240 Proton Rd, Dallas, TX

**Dental plans are provided and administered by Harbor Dental Plan, LP. Plans are self-owned and may transfer with employment.**

Company Name (Legal Name)		DBA (if applicable)	
Street Address (not P.O. Box)	City	State	Zip
Bill Address (if different than above)	City	State	Zip
Company Contact Person - Title	Phone Number ( )	Fax Number ( )	
E-Mail Address	Federal Tax ID Number		
Employer Classification <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other <b>SIC Code:</b>			

**Effective Date:**  1<sup>st</sup> of the month or  15<sup>th</sup> of the month only

**Employer Contribution(s)**

	Employer's Contribution for Employee Coverage % Contribution	Employer's Contribution for Dependent Coverage % Contribution
Dental Fee For Service Plan	_____ %	_____ %

**Section 125 Plan**

**Does the group have a flex plan under Section 125 of the Internal Revenue Service code?**  Yes  No

**Employee Eligibility**

Full-time  Part-time  Contract  Temporary  All

Total number of employees: \_\_\_\_\_

**Eligibility date will be the 1<sup>st</sup> of the policy month following the waiting period.**

**Waiting period for all employees:**  0 months (only if paid annually)  1 month  2 months  3 months

**Prior Carrier Information**

Was group covered by another carrier? <input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Carrier: _____ Type of coverage: <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO/POS <input type="checkbox"/> DMO <input type="checkbox"/> Discount
Will Harbor Dental Plan be replacing prior carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No
Will Harbor Dental Plan be offered as an alternative benefit to Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Signature Section**

Participating Dentists and other dental care providers are independent contractors and are neither agents nor employees of Harbor Dental Plan, LP. Harbor Dental Plan, LP does not provide dental care services and, therefore cannot guarantee any results or outcome of services.

I hereby apply for the coverage(s) with Harbor Dental Plan, LP; I certify that all information provided in this application is accurate and complete. The undersigned, requesting coverage for its eligible employees under the policy as of the effective date requested or as of the date of approval of the Employer for participation under the Agreement, whichever is later, and continue as long as the Employer remains actively in business; and agrees to make the required contributions. In the event of default, it will be liable to the insurer for such unpaid contributions for the coverage period, and such insurer will terminate coverage for non-payment.

Signed By: \_\_\_\_\_  
Authorized Applicant Title

\_\_\_\_\_  
City, State Company Name

\_\_\_\_\_  
Witness Date

Agent/Broker Name: \_\_\_\_\_ Tax ID/SSN: \_\_\_\_\_

Agency Name: \_\_\_\_\_ HDP Agent Number: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_