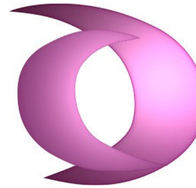
Group Dental and/or Vision Plans
Aggregate Stop Loss Coverage

DENTAFITS, Inc. provides 100% Aggregate Stop Loss Insurance for Employer sponsored self-insured Group Dental and/or Vision Plans. There are minimum Employer contribution as well as Employee and Dependent participation requirements.

Groups of 50 or more Employees will be considered, with a minimum annual premium of $1,500 for the standard (12/12) Dental and/or Vision Plans, and $3,000 for extended contract (12/15) Dental and/or Vision Plans.

The Stop Loss insurers for these programs are "AM Best" rated Insurance Companies, and our program is available in all 50 states.

To obtain a quote for Group Dental and/or Vision Stop Loss insurance, please provide us with the following information:



DENTAFITS, Inc.
400 S. El Cielo Road, Suite G
Palm Springs, CA 92262
Phone: (760) 318-6288
Fax: (760) 323-1896
E-mail stoploss@dentafits.com

QUOTE REQUEST FOR AGGREGATE STOP LOSS

A. REQUESTED BY: ☐ Agent/Broker ☐ TPA ☐ Other____________ Date:________________

Name:____

Company:____

Address:____

City:____________________________ State:__________ Zip:____________

Phone:(____)______________Ext:__________ Fax:(____)____________________

Mobile:(____)____________________________ E-mail:________________________

B. EMPLOYER INFORMATION: No. of Locations:____________________

Company:__________________________ Type of Industry:____________________

Address:____

City:____________________________ State:__________ Zip:____________

Total Eligible Employees:________________ Total Enrolled Employees:______________

Employer's Contribution: ________ % of Employee Cost __________ % of Dependent Cost

Will the Plan(s) cover Retirees? ☐ Yes ☐ No

C. NEW PLAN ADMINISTRATION:

Who will be the Plan Administrator:________________________________

Mailing Address:____

City:____________________________ State:__________ Zip:____________

E-mail:__________________________ Phone:(____)____________________

	EE Only	EE + 1/ Spouse	EE + Child(ren)	EE + Family
What is their Admin Fee?	$______/Mo	$______/Mo	$______/Mo	$______/Mo

D. REQUESTED COVERAGE: Proposed Effective Date___________________

Coverage:
☐ Dental
☐ Vision
☐ Dental with Vision

Contract:
☐ 12/12
☐ 12/15

Orthodontia: Waiting Periods:________Mo's
☐ Not Offered ☐ Separate Benefit ☐ Included in plan
___________% to $_______/Yr to $_______/Lifetime
☐ Child Only to Age________ ☐ Adult and Child

DR/DA Dental Plan Design:
Please attach a copy of the ADA cost estimates for the proposed DR/DA plan

Plan Design #1:

________ % of First $__________
$_______ Deductible/Yr
________ % of Next $__________
________ % Excess to $__________Max/Yr

Plan Design #2:

________ % of First $__________
$_______ Deductible/Yr
________ % of Next $__________
________ % Excess to $__________Max/Yr

Indemnity Dental Plan Design:
UCR @_______% of MDR

Plan Design #2:

Deductible/Yr $_________
Maximum/Yr $_________

Preventive @ _____%
Exams/X-Rays
Prophy (2x)
Child Fluoride/
Sealants (1x)

Special @ _____%
Major Oral Surgery
Endodontics
Periodontics
Waiting Period:___Mo's

Basic @ _____%
Fillings
Simple Oral Surgery
Space Maintainers

Major @ _____%
Crowns/Bridges
Onlay/Inlay
Dentures
Waiting Period:___Mo's

E. CURRENT PLAN INFORMATION:

Existing Carrier:_________________________________
Renewal Date:_________________________________

	EE Only	EE + 1/ Spouse	EE + Child(ren)	EE + Family
Current Enrollment	_______	_______	_______	_______
Current Premium Rates	$_______	$_______	$_______	$_______
Renewal Premium Rates	$_______	$_______	$_______	$_______

Does this plan cover Retirees? ☐ Yes ☐ No

Plan Design:

Deductible/Yr $_________
Maximum/Yr $_________
Preventive @______%
Basic @______%
Special @______%
Major @______%
Ortho @______%
Other:___________________
____

Please attach, on a separate sheet, the most recent month by month claims experience and the existing Summary Plan Document (SPD).

F. BENEFIT PAYMENTS

(a) Will this benefit plan accept benefit assignments? [ ] Yes [ ] No

(b) Will this benefit plan require "pretreatment review"? [ ] Yes [ ] No

If yes, give dollar amount ______________________________

(c) Will benefit plan reimbursement/payment be based upon a Fee Schedule? [ ] Yes [ ] No

If a Fee Schedule will be utilized, please send a copy of the Fee Schedule.

G. EMPLOYEE ELIGIBILITY:

An eligible FULL TIME employee is defined as:

working ______hours per week, or Other____

An eligible PART TIME employee is defined as:

working ______hours per week, or Other____

The initial waiting period:

(a) for current employees on effective date is none [ ], or Other_____________________

(b) for future employees is _____month(s), or _____days, or Other_____________________

New hires to be effective on the first of the month following waiting period [ ] Yes [ ] No, or

Other____

Retiree Eligibility: [ ] Yes [ ] No

If Yes, Detail Eligibility____

H. CONTINUING COVERAGE due to absence from work will be as follows:

For Absence Due To	Maximum Continuation Period
Temporary Layoff	_______Months
Approved Leave of Absence	_______Months
Part-time Employment	_______Months
Injury or Sickness	_______Months

I. DEPENDENT ELIGIBLITY: An eligible dependent is defined as an eligible employee's

Spouse [ ] Yes [ ] No Domestic Partner [ ] Yes [ ] No,

Unmarried children from ________to age ______and each unmarried child to age _____who is a full time student. A full time student is one who is enrolled for _____semester hours for credit in an accredited junior college, college or university.

COMMENTS, NOTES, ADDITIONAL INFORMATION:

____

____

____