EMPLOYER GROUP APPLICATION

To completed by Argus:
☐ **INITIAL APPLICATION**
☐ **RENEWAL**

GROUP# ___________
EFF. DATE___________

I. EMPLOYER INFORMATION

COMPANY NAME
Exact Legal Name of Company ____
Doing Business As ____ Employer Federal Tax ID # ____________________
Business name to appear on the Billing Invoice and Member ID Cards ____
STREET ADDRESS (Principal place of business in Florida)
Street ____
City/State ________________________________ Zip Code ____________ County ____________________
BILLING ADDRESS
Street ____
City/State ________________________________ Zip Code ____________ County ____________________

OTHER LOCATIONS TO BE INCLUDED/EXCLUDED IF MULTI-SITE EMPLOYER (Please list separately and attach to this application)
CONTACT PERSON
Name and Title of Designated Contact __________________________________ Title ____________________________________
Phone Number of Contact _____________________ Ext ______ E-mail Address ____

II. PLAN INFORMATION

PLAN TYPE

☐ Voluntary (100% Employee Paid ☐ Contributory (Employee and Employer shared) ☐ Employer Paid

ELIGIBILITY
Identify which Employees are eligible to participate:

☐ Full-time Employees (Employees who work at least ___hours per week): ☐ Leased Employees ☐ Retirees

☐ Part-time Employees ☐ Temporary/Seasonal Employees ☐ Other ______________

Total Number of eligible Employees at the time of this Application: ______

Identify which dependents of the Employee are eligible to participate:

☐ None

☐ Spouses of the opposite sex: ☐ Spouses of the same sex ☐ Domestic partners

☐ Biological and adopted children (or children placed for adoption): ☐ Foster children ☐ Step-children

☐ Other ___________

WAITING PERIOD
New Employees (those hired after the Plan Effective Date below) who are otherwise eligible and enroll within the established timeframe will be effective for coverage on the 1st of the month following _____ days (0, 30, 60, or 90) of their employment date.

EMPLOYER GROUP APPLICATION

III. BENEFIT SELECTION

PLAN DESIGN

The Employer is applying for the following plan design: ☐ Master Plan ☐ Freedom Plan

PLAN RATES

The following monthly premiums shall apply to the coverage selected:

Master Plan

Individual only	**$**
Individual + 1	**$**
Individual + Family	**$**

Freedom Plan

Individual only	**$**
Individual + Spouse	**$**
Individual + Child(ren)	**$**
Family	**$**

A deposit of $_______ is being submitted with this Application and will be applied toward the first month's premium payment obligation.

REQUESTED PLAN EFFECTIVE DATE: ________________________

OTHER COVERAGE

Does the Company currently have group dental coverage? ☐ Yes ☐ No

If yes, name of the current group carrier: _____________________________

IV. AGENT/BROKER INFORMATION

In order to receive correspondence related to this case and proper commission credit, this form must be completed in its entirety. For faster processing, please attach a copy of the quote.

General Agency (if applicable) ____

Agency Name ___________________________________ Agency Tax ID# ________________ Argus Vendor# ________________

Street Address __________________________________

City/State _________________________________ Zip Code _______________ County ________________________

Telephone Number (____) _________________________ Fax Number (____) _____________________

Agent Name (1) ____ FL License ID# _______________ Argus ID# __________

Agent (1) E-mail Address ____

Agent (1) Signature X ____ **Date** __________________________

EMPLOYER GROUP APPLICATION

V. AGREEMENT

Argus Dental & Vision, Inc. ("Argus"), a Florida corporation, is a Prepaid Limited Health Service Organization licensed under Florida Statutes, Chapter 636, a Discount Medical Plan Organization licensed under Florida Statutes, Chapter 636, and a Third Party Administrator licensed under Florida Statutes, Chapter 626. If Argus enters into an agreement with the Employer, the rights and obligations of the parties shall be governed by such agreement.

VI. CERTIFICATION

I, ___________________, the __________ of the Employer submitting this Application, hereby attest that:

- This group is a valid employer and is not formed for the purpose of securing dental benefit coverage.
- The individuals included in the group identified in this Application are employees of the Employer (and their dependents) and have not been added for the purpose of securing dental benefit coverage.
- The Employer has its principal place of business in the State of ________________________.
- I certify that the information provided above is true to the best of my knowledge.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Applicant/Employer	
Signature	
Print Name	
Title	
Date Signed	