NEW BUSINESS SUBMISSION FORM

Agent Information

NEW BUSINESS SUBMISSION CHECKLIST

Please make sure the following is submitted with **ALL** new cases. We cannot process a case without **ALL** of the following information:

___ Completed Employer Group Application
___ Completed Employee Enrollment Forms ***OR*** Electronic Census Info (we supply the spreadsheet)
___ 1st Month's Premium
___ Producer Licensing Forms (If applicable)
___ Employer Verification of Eligibility Form
___ Copy of Quoted Rates
___ Completed Submission Form

TAKE OVER CREDIT CASES

Please make sure ALL of the following information is enclosed on all prior coverage take over cases:

___ Copy of prior plan Schedule of Benefits and rates
___ Copy of prior plan's last billing statement listing each employee covered

Prior credit is available only to employees listed on the prior carrier bill and that are enrolled on the initial effective date of the plan and approved by Argus Dental & Vision, Inc.

GUIDELINES AND PROCEDURES

1) All coverage will be effective on the first of the month, except when necessary for takeover cases. All groups with initial effective dates other than the 1st of the month will be converted to the 1st of the month and will become the anniversary date.
2) Voluntary Groups: Payroll deductions should begin 4-6 weeks prior to effective date in order to satisfy premium prior to the effective date.
3) In no event will claims be paid prior to the effective date and the date the group setup is complete.
4) Applications, premium and enrollment forms must be received before the requested effective date month.
5) Upon receipt of complete documentation, Argus Dental & Vision, Inc. will assign a group number and issue administrative instructions to the employer. I.D. Cards and Certificates will be sent to employees unless requested otherwise.
6) Please submit new cases to the following address:

Argus Dental & Vision, Inc.
4010 W. State Street
Tampa, FL 33609
Email: arguschoice@argusdentalvision.com **Fax: 813-440-4538**

VERIFICATION OF ELIGIBILITY FORM

EMPLOYER

NEW BUSINESS SUBMISSION

Please complete this form of eligibility and provide with new case submission documents. Statements made herein may be used to contest a claim of the validity of any policy issued. If a policy is issued, please see such policy for more information.

1) Employer's name_____
2) Employer's Phone Number_____
3) Total number of employees on payroll_____
4) Total number of employees working part-time (as defined by employer in the employer application) and includes temporary and/or seasonal employees_____
5) Total number of employees in waiting period_____
6) Number of full-time eligible employees (subtract numbers 4 & 5 from number 3)_____
7) Total number of employees who are covered under their spouse's plan (an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file)_____
8) Number of eligible employees (subtract 7 from 6)_____
9) Number of full-time employees enrolled_____
10) Premium information:
    ___ 100% Employer Paid, or
    ___ Employer pays _____% of employee premium, and
    ___ Employer pays _____% of dependent premium

AGREEMENT AND SIGNATURES

It is understood and agreed as follows:

1) No coverage is effective until approved by Argus Dental & Vision, Inc.
2) Coverage will be effective with regard to those individuals listed in the Eligibility section of the application on the latest of the following dates: a) effective date approved by the company, b) the date the application is signed, or c) the date the first premium is paid in full.
3) No agent has the authority to waive any of the company's right or requirements, or to make or alter any contract or policy.
4) The employer applicant agrees to notify Argus Dental & Vision, Inc. of any changes to the above numbers representing a change of five percent (5%) or more and the employer further agrees to provide Argus Dental & Vision, Inc. with payroll records verifying number of employees upon request.
5) The employer applicant agrees and understands that if the contributory status or participation percentages change, that Argus Dental & Vision, Inc. reserves the right to adjust the premiums and rates accordingly.

Dated at_____this____day of _____, 20_____.

_____ _____

Signature of Writing Agent Agent ID | Employer Applicant Signature

_____ _____

Type or Print Agent's Name(s) | Type or Print Name

_____ _____

Agent's Business Address (City/State/Zip) | Title

_____ _____

Agency Agency Code | Company Name

NEW BUSINESS FORM

Policy Administration Information

NEW BUSINESS SUBMISSION

The following information needs to be completed in order to assist Argus Dental & Vision, Inc. in administering your dental plan. Please place a check mark in the appropriate box or circle where indicated.

Employer Name: _____ Phone Number: _____

Employer Contact:_____ Email: _____

Agent Name:_____ Email: _____

INITIAL ENROLLMENT PROCESS

Employer wishes to submit initial enrollment as follows (check one):

___ Electronic enrollment via excel spreadsheet

___ Submit hardcopy enrollments to ***Argus Dental & Vision, Inc.*** or ***Agent*** (circle one)
(Argus Dental & Vision, Inc. to provide forms)

ADMINISTRATION KITS (WELCOME TO ARGUS DENTAL & VISION, INC.)

Argus Dental & Vision, Inc. to forward the Administration Kit and Instruction Guide as follows (check or circle as indicated):

___ Send via the internet to Agent or Employer (circle one)
(Above information will be emailed within 2 business days of receipt of all completed requirements)

___ Send hardcopy directly to ***Agent*** or ***Employer*** (circle one)

DENTAL INSURANCE POLICY AND CERTIFICATES

Argus Dental & Vision, Inc. to forward the Policy and Certificates as follows (check or circle as indicated):

___ Send via the internet to Agent or Employer (circle one)

___ Send hardcopy directly to Employer

___ Send hardcopy directly to Employees

Note: Based on Insurance Regulations, it is required that the Employer provide the Insurance Certificates to the Employees either as a hardcopy or through online access.

The undersigned acknowledges the above instructions and understands the importance of providing the Employees the Insurance Certificates immediately upon receipt.

_____ _____

Agent's Signature Date

PAYMENT AUTHORIZATION FORM

argus dental vision
a premier benefits organization

GROUP NAME:

Monthly Premium: Dental $_____ + Vision $_____ = Total Monthly Premium $_____

Method of Payment (Select One)

CHECKING ACCOUNT (ACH)

☐ **Monthly Bank Account Debit**
*Please submit a voided check

_____
Bank Name

_____
Routing Number

_____
Account Number

CREDIT CARD

☐ **Monthly Credit Card**
*Please provide your credit card information below:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

_____
Name on Card

_____
Credit Card Number

_____ _____
EXP CCV Code

AUTHORIZATION AGREEMENT

I authorize Argus Dental & Vision, Inc. to initiate electronic debits to the account listed above for payment of my insurance premium. I certify that I am an authorized user on the above listed account. I acknowledge that debits to my account for premium due will occur on a regular recurring basis based on the payment frequency indicated above until such time as coverage terminates or until I notify Argus Dental & Vision to terminate these transactions.

I understand that it may take up to two weeks to process a request to discontinue recurring payments. In order to make changes to this authorization (such as change in bank account, method of payment, or termination of payment) I must provide Argus Dental & Vision at least two weeks' notice in advance of the next scheduled payment date.

Based upon my authorization Argus Dental & Vision will debit my account for any current and outstanding due premiums on the 20th of each month for the following month's premium. Premiums are due on the 1st of each month. For initial payments I acknowledge that Argus Dental & Vision may debit my account upon acceptance and approval of my application.

If any authorized payment is returned or dishonored by my bank, I acknowledge that I am responsible for any fees my bank may charge. I understand also that I may incur a return payment fee of $25 charged by Argus Dental & Vision if the return is due to insufficient funds. I acknowledge that such a fee, if charged, may be automatically debited from my authorized account on the next payment date. I am responsible for remitting payment within the policy grace period. If payment is not received by Argus Dental & Vision within the defined grace period I acknowledge that my coverage may be cancelled in accordance with the terms of the insurance contract.

I acknowledge that the origination of these electronic transactions (ACH and Card) must comply with applicable provisions of US Law.

Printed Name _____

Signature _____ **Date** _____