

Dental Pay Plus

Dental Quote Information

Company Name: _____ Contact: _____
Company Address: _____ Phone: _____
_____ Fax: _____

Total Number of Full-Time (30 hrs. + per week) Employees: _____ Single: _____ Family: _____

Total Number of Eligible Employees: _____ Single: _____ Family: _____

(excluding employees covered under another plan or not yet eligible for coverage)

Number of Employees Presently Enrolled: _____ Single: _____ Family: _____

Annual Percentage Employee Turnover Rate: _____%

Is There a Dental Plan Currently in Place? Yes No

If Yes, Name of Present Carrier: _____ How long with carrier: _____

Do Employees Contribute to Premium?: _____ How much: _____%

If no plan in affect, who will pay proposed premium?: Employee: _____% Employer: _____%

Present Dental Benefits:

Annual Deductible: _____ Annual Maximum: _____

Preventative Services Covered at: _____% Minor Restorative Services Covered at: _____%

Major Restorative Services Covered at: _____% Orthodontia Benefit: _____

What Were Total Claims Paid Last Year: _____

What Was Total Premium Paid Last Year: _____

Are There Employees Located out of the WNY Area: _____

If So, Where and How Many: _____

Please List Job Descriptions of Employees: _____

