The Dental Care PLUS GROUP
The plus is service.

The Real Estate Agent

HMO PLAN
VOLUNTARY

	Basic	Enhanced
Maximum / calendar year / individual	**$750**	**$1500**
Orthodontic Lifetime Maximum	**N/A**	**N/A**
Annual Individual Deductible	**$50**	**$50**
Annual Family Deductible	**$150**	**$150**
(Deductibles apply to Basic and Major Benefits only)		

Percentage of Payment by Dental Care Plus:

Preventive Benefits	**100%**	**100%**
	After $10 co-pay	*After $10 co-pay*
Basic Benefits	**50%**	**60%**
Major Benefits	**0%**	**40%**
Orthodontic Benefits	**N/A**	**N/A**
Endodontic Benefits	**BASIC**	**MAJOR**
Periodontic Beneifts	**BASIC**	**MAJOR**

A complete description of covered services, limitations and exclusions is available in the Individual Certificate. Members must receive services from a Dental Care Plus dentist.

These rates include the Total Vision Services Program.

Tier	Basic	Enhanced
Single	$27.08	$33.67
Double	$51.43	$63.96
Family	$89.33	$111.09

The Real Estate Agent Dental Plan

Enrollment Instructions and Checklist

INSTRUCTIONS:

1. Review all materials.
2. Be prepared to select desired dental benefit option, "**Basic Plan**" or "**Enhanced Plan**".
3. Complete "***Affidavit***" of Board of Realtor membership.
4. Complete "***Application For Master Group Contract***" (Note: this form is set up for "Employers" to complete. For this plan and coverage, the individual real estate professional is the "Employer".

   Form Completion Assistance: Where possible, answers are provided and the form has been pre-completed (you may amend if any answers are inappropriate for your situation). *Employer Group Information:* please complete. *Eligibility:* not applicable. Pages 2 and 3 describe the two different plans offered. Select "Basic" (page 2) or "Enhanced" (page 3) by indicating "Yes" at appropriate"*Plan Election" under "Benefit Plan Information"*. On the page of your plan election, circle the appropriate coverage effective and renewal date (January 1 or July 1) under *"Contract Charges / Rates"* and *"Effective & Anniversary Dates"*. Complete *"Contact Information"* and sign and date under *"Signatures"*.
5. Complete "***Enrollment Form***" (please sign, date, select plan option, "Basic" or "Enhanced", and enter "Effective Date" with either "January 1" or "July 1".
6. Complete "***Credit Card Premium Payment Authorization***" (Note: your name is to be printed in the first three spaces and in the third paragraph above where you must sign as "Authorized Representative"; also note strict confidentiality with regard to credit card information).
7. Keep copies of all forms for your records.
8. Review below "***CHECKLIST***" and mail original forms as instructed.
9. Expect to receive Identification Card(s) in approximately two to three weeks.
10. Please take time to visit the Dental Care Plus website (www.dentalcareplus.com).
11. Make dental appointment with Dental Care Plus participating dentist.

CHECKLIST:

☑ "AFFIDAVIT" (one page)

☑ "APPLICATION FOR MASTER GROUP CONTRACT" (two pages)

☑ "VOLUNTARY ENROLLMENT FORM" (one page)

☑ "CREDIT CARD PREMIUM PAYMENT AUTHORIZATION" (one page)

Remember to ***sign and date all forms*** and mail original forms to:

DENTAL CARE PLUS
ATTN: STEPHANIE BINFORD
100 CROWNE POINT PLACE
CINCINNATI, OH 45241

Note: The Real Estate Agent Dental Plan is available to qualified members and affiliate members of participating Board of Realtors organizations through Dental Care Plus with products distributed by The Scheller Bradford Group. No Board of Realtors organization is a sponsor of or is otherwise associated with the Plan, nor does any Board of Realtors organization receive any financial benefit as a result of the Plan being offered to its membership.

Dental Care PLUS
The plus is service.

Dental Care Plus Group #_____
(DCP use only)

Underwritten by Dental Care Plus, Inc.
100 Crowne Point Place
Cincinnati, Ohio 45241

APPLICATION FOR MASTER GROUP CONTRACT

The Enrolling Unit/Employer named below hereby makes application to Dental Care Plus, Inc. for a Master Group Contract to be issued in accordance with the specifications of the Application.

Please Print Clearly or Type Requested Information:

EMPLOYER GROUP INFORMATION

Legal Name of Enrolling Unit/Employer:
The Real Estate Agent Dental Plan **Applicant Name**: _____

Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:		
Mailing Address (if different from above):	City:	State:	Zip Code:

Legal Status: □ Corporation □ Partnership □ Proprietorship □ Trustee

Other (please specify): _____

Nature of Business or Industry: Real Estate

Subsidiaries – The following subsidiaries, affiliates or other organizations will be included under this Master Group Contract:

N/A

ELIGIBILITY

All active, full-time employees, working at least 30 hours per week are eligible:

X Yes □ No

If no, list the classes of employees who are eligible: _____

Total number of full-time, eligible employees: One (1)

Employee Waiting Period

New employees will be effective:

□ first of the month following date of hire □ date of hire
□ 30 days, first of following month □ 31st day of employment
□ 60 days, first of following month □ 61st day of employment
□ 90 days, first of following month □ 91st day of employment
X Other (please specify): N/A

"BASIC PLAN" - CONTRACT CHARGES / RATES

All Contract Charges ("Rates") shall be paid by the Enrolling Unit/Employer to Dental Care Plus, Inc. at its Home Office on or before each due date. **The first Contract Charge is due on January 1, 2010 or July 1, 2010 (please circle) and subsequent Contract Charges are payable monthly.**

Select one tier structure:

□ Composite Rate: **$**_____

□ Two tier Rates: Single: **$**_____ Family: **$**_____

X Three tier Rates: Single: **$ 25.31** EE& One Dependent: **$ 48.07** Family: **$ 83.49**

□ Four tier Rates: Single: **$**_____ EE& Spouse **$**_____ EE& Child(ren): **$**_____ Family: **$**_____

Will the employees be required to contribute toward the cost of the insurance? □ Yes □ No

If yes, indicate the percentage or dollar amount of the cost of each coverage the employee will pay:

Employee: _____

Dependent: _____

EFFECTIVE & ANNIVERSARY DATES

Effective Date: The Master Group Contract will be delivered and governed by the laws of the state where the Contract was issued and shall take effect on **January 1, 2010 or July 1, 2010 (please circle)** but only if this application is accepted in writing by Dental Care Plus, Inc. at its Home Office.

Renewal / Contract Anniversary Date:

January 1, 2011 or July 1, 2011 (please circle)

BENEFIT PLAN INFORMATION

Benefit Plan Number: 236- **BASIC** **Plan Election** _____ **Yes** _____ **No**

	Annual Individual / Family Deductible Amount	HMO Coinsurance Percentage
Preventive Benefits	no deductible	**100 %**
Basic Benefits	**$ 50/150**	**50 %**
Major Benefits	**$ n/a**	**n/a %**
Orthodontic Benefits	no deductible	**n/a %**

Variable Options: Endodontics: X Basic □ Major

Periodontics: X Basic □ Major

Implant Coverage (if elected, will be Major Benefit): □ Yes □ No **n/a**

Preventive Visit Co-pay: **$ 10** (applies to routine exams and cleanings per visit)

Annual Maximum Benefit (except ortho): Amount **$ 750** X Calendar Year □ Plan Year

Orthodontics: □ Yes X No If Yes, Lifetime Maximum Benefit **$ n/a**

Adult Orthodontics (includes Subscriber and Spouse): □ Yes X No

Child Orthodontics (includes eligible dependent Children under age 19): □ Yes X No

"ENHANCED PLAN" - CONTRACT CHARGES / RATES

All Contract Charges ("Rates") shall be paid by the Enrolling Unit/Employer to Dental Care Plus, Inc. at its Home Office on or before each due date. **The first Contract Charge is due on January 1, 2010 or July 1, 2010 (please circle) and subsequent Contract Charges are payable monthly.**

Select one tier structure:

□ Composite Rate: **$**_____

□ Two tier Rates: Single: **$**_____ Family: **$**_____

x Three tier Rates: Single: **$ 31.47** EE& One Dependent: **$ 59.78** Family: **$ 103.82**

□ Four tier Rates: Single: **$**_____ EE& Spouse **$**_____ EE& Child(ren): **$**_____ Family: **$**_____

Will the employees be required to contribute toward the cost of the insurance? □ Yes □ No

If yes, indicate the percentage or dollar amount of the cost of each coverage the employee will pay:

Employee: _____

Dependent: _____

EFFECTIVE & ANNIVERSARY DATES

Effective Date: The Master Group Contract will be delivered and governed by the laws of the state where the Contract was issued and shall take effect on **January 1, 2010 or July 1, 2010 (please circle)** but only if this application is accepted in writing by Dental Care Plus, Inc. at its Home Office.

Renewal / Contract Anniversary Date:

January 1, 2011 or July 1, 2011 (please circle)

BENEFIT PLAN INFORMATION

Benefit Plan Number: 237- **ENHANCED**

Plan Election _____ Yes _____ No

	Annual Individual / Family Deductible Amount	**HMO Coinsurance Percentage**
Preventive Benefits	no deductible	**100 %**
Basic Benefits	**$ 50/150**	**60 %**
Major Benefits	**$ 50/150**	**40 %**
Orthodontic Benefits	no deductible	**n/a %**

Variable Options: Endodontics: □ Basic x Major

Periodontics: □ Basic x Major

Implant Coverage (if elected, will be Major Benefit): □ Yes □ No **n/a**

Preventive Visit Co-pay: **$ 10** (applies to routine exams and cleanings per visit)

Annual Maximum Benefit (except ortho): Amount **$ 1500** x Calendar Year □ Plan Year

Orthodontics: □ Yes x No If Yes, Lifetime Maximum Benefit **$ n/a**

Adult Orthodontics (includes Subscriber and Spouse): □ Yes x No

Child Orthodontics (includes eligible dependent Children under age 19): □ Yes x No

CONTACT INFORMATION

Please name the **coordinator** of your dental benefit plan:

Name: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

Please name the **finance contact** of your dental benefit plan:

Name: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

SIGNATURES

The Enrolling Unit/Employer hereby agrees and understands that the Master Group Contract issued is based on the information provided in this Application, which Enrolling Unit/Employer hereby represents is true and accurate, and that acceptance of the Master Group Contract by the Enrolling Unit/Employer constitutes agreement to all terms and conditions of the Application and the Master Group Contract. The Master Group Contract shall be deemed accepted if it is not returned by the Enrolling Unit/Employer to Dental Care Plus, Inc. by registered mail within ten (10) business days of receipt. A copy of this Agreement shall be attached to and made a part of the Master Group Contract issued to the Enrolling Unit/Employer. **Dental Care Plus, Inc. reserves the right to rescind the Master Group Contract or to take any other action which Dental Care Plus, Inc. deems necessary if the information provided on this Application is false or inaccurate.**

Ohio Fraud Notice – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Kentucky Fraud Notice – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

For the Enrolling Unit/Employer:

By _____

Title _____ Date _____

For Dental Care Plus, Inc.:

By _____

Title _____ Date _____

Dental Care Plus, Inc.
100 Crowne Point Place • Cincinnati, OH 45241
Phone (513) 554-1100 • 1-800-367-9466

☐ BASIC PLAN

☐ ENHANCED PLAN

ENROLLMENT FORM

ALL SECTIONS MUST BE COMPLETED FOR APPLICATION TO BE PROCESSED.

SOCIAL SECURITY NUMBER ---- ---	GROUP NUMBER	EMPLOYER AND LOCATION	
EMPLOYEE LAST NAME FIRST NAME MI		EMPLOYEE'S HOME PHONE	EMPLOYEE'S WORK PHONE
HOME ADDRESS APT#		SEX	DATE OF BIRTH
CITY STATE ZIP CODE		COUNTY IN WHICH YOU RESIDE	
MARITAL STATUS: ☐ SINGLE (01) ☐ MARRIED (02)	EMPLOYMENT DATE	EFFECTIVE DATE	

APPLICATION FOR DENTAL COVERAGE (CHECK THOSE THAT APPLY) ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD(REN)

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE COVERED BY THE PLAN

	NAME – IF LAST NAME DIFFERENT FROM ABOVE INDICATE LAST NAME	RELATIONSHIP	SEX	BIRTH DATE
01		SPOUSE		
02				
03				
04				
05				
06				

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _____

IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:

_____

REFUSAL/WAIVER – COMPLETE ONLY IF YOU ARE DECLINING COVERAGE FOR YOURSELF OR ANY DEPENDENT

I DECLINE COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN

REASON FOR REFUSAL:

_____

On behalf of myself and any dependants listed above, I hereby apply for coverage under the Master Group Contract issued to my employer by Dental Care Plus, Inc. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any changes provided for therein. I understand that certain services may require copayment or deductible, payable by me (or my dependents) directly to the provider of such services. I authorize my employer to deduct the necessary contributions, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with the plan, and that all acts performed by him and all notices given to him in such dealings are binding upon me, as not prohibited by statute or regulation.

I hereby waive the dentist-patient privilege and authorize any dentist or other provider of dental services to give Dental Care Plus, Inc., its agents and representatives any information concerning the claims for reimbursement for covered services of any person included under such coverage, including the undersigned, the undersigned's spouse and the undersigned's dependents.

To the best of my knowledge, the above information is complete, true, and correct. In the absence of fraud, however, all statements made by applicants or by an insured person shall be deemed representations and not warranties.

X EMPLOYEE SIGNATURE _____ DATE_____

CITY/STATE _____

Fraud Notice - Ohio Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Fraud Notice – Kentucky Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Credit Card Premium Payment Authorization

The Dental Care Plus Group (DCPG), sells goods and/or services to (a.)_____. **DCPG** desires the flexibility to invoice and withdraw monies for such goods and/or services by payment through an automated credit card payment process and (a.)_____ agrees to grant such ability.

Therefore, (a.)_____ hereby (i) authorizes **DCPG** for automatic payment of his/her **DCPG** invoice, (ii) allows **DCPG** to automatically charge his/her account in the amount of his/her monthly invoice, (iii) agrees that **DCPG** or his/her financial institution can cancel automatic payment for his/her account at any time, with or without prior notice to him/her, (iv) agrees that this agreement remains in effect until canceled by him/her, **DCPG,** or his/her financial institution, (v) directs that all such credit card payments be processed as provided below. Once automated payment takes effect, the full invoice for the month will be charged to the member's credit card each month 2-5 business days from the first of the month due.

Credit Card Type: _____
Name exactly as it appears on card: _____
Credit Card Number: _____
Expiration Date: _____(b.)
Signature of Card Holder: _____
Phone Number (with area code): _____

(a.)_____ will give thirty (30) days advance notice in writing to **DCPG** of any changes in its depository institution or other payment instructions.

_____
(Signature of Authorized Representative)

_____
(Date)

Notice of Privacy Practices: The information you have provided above is kept confidential in accordance with our privacy practices and will not be disclosed to anyone for any reason.

(a.) Your Name
(b.) You will be asked for updated Credit Card information upon current card expiration

AFFIDAVIT

of Board of Realtor Membership and for Enrollment into The Real Estate Agent Dental Plan

With signature below, the Signor affirms and attests to being a qualified dues paying member or affiliate member in good standing of a participating Board of Realtors member organization.

Member Name: _____

Board Membership: _____

_____

Member Signature

_____

Date

BOR membership status may be audited at any time

John Harder
The Scheller Bradford Group
463 Ohio Pike, Suite 303
Cincinnati, OH 45255
(513)528-2400; (866)528-2403
john.harder@schellerbradford.com

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