Group Dental Program

MERCER

FOR MEMBERS OF THE COUNTY MEDICAL ASSOCIATIONS & SOCIETIES/NORCAP 1-454

★ **COVERAGE REQUESTED:** ☐ **PHYSICIAN** (PLEASE FILL OUT SECTIONS 1, 3 & 4) ☐ **EMPLOYEE** (PLEASE FILL OUT SECTIONS 1, 2, 3 & 4)
PARTICIPATION REQUIREMENTS: GROUPS REQUIRE 75% PARTICIPATION IN THE SAME PLAN.

SECTION 1 Employer/Physician Information (all applicants)

Employer/Physician Name _____

Employer/Physician Address _____

City _____ State ____ ZIP _____ Phone # (____) _____

SECTION 2 Employee Information (employees only)

Employee Name (last, first, middle initial) _____

Employee Home Address _____

City _____ State ____ ZIP _____ Occupation _____

SECTION 3 General Information

Sex ☐ Male ☐ Female Date of Birth _____ Social Security Number _____ Date Hired/Rehired _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed Hours Worked Per Week _____

SECTION 4 Dependent Coverage (list all dependents to be covered)

Dependent Coverage?: ☐ Yes ☐ No *(If "No" and you have eligible dependents, please complete a Refusal of Group Insurance Form)*

Dependent Coverage For: ☐ SPOUSE ONLY ☐ SPOUSE & CHILDREN ☐ CHILD(REN) ONLY

(Dependents cannot be enrolled for coverages declined by the employee)

Dependent Name	Date of Birth	Sex	Student	Social Security Number
Spouse:		☐ M ☐ F	☐ Yes ☐ No	
Child:		☐ M ☐ F	☐ Yes ☐ No	
Child:		☐ M ☐ F	☐ Yes ☐ No	
Child:		☐ M ☐ F	☐ Yes ☐ No	
Child:		☐ M ☐ F	☐ Yes ☐ No	

If I am not required to contribute towards the cost of my plan, I must be enrolled and cannot refuse insurance.

I hereby: 1. request coverage for the Group Insurance for which I am, or may become, eligible; 2. authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance; 3. state that I became an employee on the date stated above, and do currently work the number of hours per week stated above.

I understand that, if I must contribute to the cost of the plan, I must enroll within 31 days of the date I become eligible for group insurance coverage. If I do not, my dependents and I are not insured until I submit, and The Guardian approves, evidence that I and each of my dependents are insurable.

I am a member or am employed by a member, in good standing of the _____ County Medical Association/Society.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Employee **X** _____ Date _____

Signature of Employer/Physician **X** _____ Date _____

To be completed by insurance company _____

Group Number **271965** Class _____

GG-981 WRO 1/01

OVER, PLEASE

Program Rates
Monthly* Premiums Effective January 1, 2013
(Rates subject to change January 1, 2015)

* Monthly rates are shown to the right. However, the program is billed on a quarterly basis. To determine your quarterly rate, multiply the monthly rate by three.

Dental PPO Program	
Individual Only	$60.80
Individual and 1 Dependent	$117.99
Individual and Family	$191.79

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO Plans:

This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect or injury. Deductibles apply. Waiting periods may also apply for some services. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments, any treatment to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. GP-1-DG2000, et al.

For more information, or answers to your questions, please call a Mercer Client Advisor at 800-842-3761.
Or email us at CMACounty.Insurance.service@mercer.com

Mail completed application to: Mercer, Attn: Association Department, 777 S. Figueroa St., Los Angeles, CA 90017

About Our Role and Compensation
The California County Medical Associations and Societies/NORCAP have selected The Guardian Life Insurance Company of America for this insurance program. Alternative insurance products may be available in the insurance marketplace. Mercer Health & Benefits Insurance Services LLC is providing this single insurer option on behalf of the California County Medical Associations and Societies/NORCAP. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon such factors as volume, growth or retention of business. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request. You may obtain this information by referring to https://www.personal-plans.com/disclosure and entering the security code E448527213395 or call us at 1-888-206-5088 for specific details.

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