The Dental Network, Inc. 10455 Mill Run Circle Owings Mills, Maryland 21117 202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

GROUP APPLICATION

RINT OR TY	TPE PLAN:	·	DA'	TE:		
Group Nam	e:					
Address:						
	Street		City	1	State	Zip Code
Telephone:	()	Con	tact:Name		Title	
Email:						
Eligibility R	Requirements:		le, employees m months and wo			
Total Numb	per of Eligible En	mployees: _	Tota	al Enrolled:		
			NUMBER	RATE	TOT	ALS
Covered Employee Only				\$	\$	
Covered Employee and Child				\$	\$	
Covered Employee and Spouse/Partner				\$	\$	
Covered Empl	oyee and Family	У		\$	\$	
First Month's	s Remittance				\$	
Effective Da	ate:		(mus	t be first day of	the month)	
nis application The Dental N	is subject to all letwork, Inc.	terms and co	onditions of the C	Group Dental So	ervices Contra	ct and approv
enefit or who k	knowingly or wi	llfully presen	ents a false or fra ts false informat onfinement in pri	ion in an applic	for payment of cation for insur	f a loss or rance is guilty
		 				_(SEAL)
TITNESS		Aut	horized Officer/	Agent of Applic	cant	
	Acknow	vledged: TH	E DENTAL NE	TWORK, INC.		

DISCLOSURE STATEMENT

Under Maryland Law, your group member may purchase a dental point-of-service option as an additional benefit. A dental point-of-service option allows your group members to obtain dental care services from dentists outside the dental provider panel under certain circumstances that are described in the group insurance certificate issued by the carrier supplying the point-of-service option. You have the choice to either pay for this dental point-of-service option, pay a percentage of the cost of this option, or require your group members to pay for the entire cost of this option. The cost of the dental point-of-service option described in the group insurance certificate issued by the carrier supplying the point-of-service option is identified in your proposal. Please indicate below the group members who have chosen this dental point-of-service option.

I HAVE READ AND UNDERSTAND THIS DISCLOSURE STATEMENT AND HAVE PROVIDED NOTICE OF THE AVAILABILITY OF THIS ADDITIONAL BENEFIT TO MY ELIGIBLE GROUP MEMBERS.

Date	Group Policyholder
	Signature
ROUP MEMBERS WHO HAVE C	CHOSEN POINT-OF-SERVICE OPTION:
(Please	e attach additional sheet, if necessary)
gent Name (Please print):	
gent Signature:	
agency Name:	
Address:	
Telephone:	Fax:
711.	