

CASE COMPLETION FORM FOR: \_\_\_\_\_  
(Group Policyholder Name)

To help ensure that your case is set up properly, the following are **standard provisions** within the EDT program and **must** be completed as follows on application GR 902 Rev. 10-02 NY:

- 7. How many hours per week equal full time employment? **30 Hours**
- 12. Effective Date and Termination Date: **First of Month Effective date/end of Month Termination date**
- 13. Premium Payment Mode (In advance): **Monthly**
- 14. The following coverages are applied for: **Employee & Dependents Benefits: Dental**

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PLEASE COMPLETE AND MAKE YOUR PLAN SELECTION

**Plan** (must select one):  Two Star  Three Star

**Annual Maximum:**  \$750  \$1,000  \$1,500  \$2,000 (10+ Enrolled only)

**U & C Out of Network:**  80th Percentile (Standard)  90th Percentile (rate load applies)

**Starter Plan:**  Yes (No major services)

**Deductible Choice:**  \$25  \$50  \$100 **Deductible waived for preventive:**  Yes /  No

**Orthodontia:**  Yes  No (minimum 5+ enrolled employees)  Adult Orthodontia (10+ Enrolled only)

\$1000  \$1500 (10+ Enrolled only)

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ADDITIONAL ENROLLMENT INFORMATION REQUIRED

**Sic Code:** \_\_\_\_\_

**Waiting Period Eligibility: Employees employed on or prior to the Effective Date:**

**Waiting Period applies?**  Yes  No

**Future Hires Waiting Period: 1<sup>st</sup> day of the month coincident with or next following (check one):**

One Month  Two Months  Three Months  Date of full-time hire  Other: \_\_\_\_\_

**Employee/Cobra Eligibility:**

**Does the group employ 20 or more employees?** (Include part time, union, etc.)  Yes  No

**Total Number of full time employees:** \_\_\_\_\_

(Include employees not to be covered)

**Total number of Cobra eligible participants:** \_\_\_\_\_

**Retired Employees:**  Covered (rate load applies)  Not Covered

Retiree Class Description: \_\_\_\_\_

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**Signature of Benefits Administrator**

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**Date**