

Employer Name \_\_\_\_\_

**Direct Reimbursement Dental Benefits Plan**  
*Enrollment Form*

Current Employee     New Employee     New Participant     Current participant     Change in family

Employee Name \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Hire \_\_\_\_\_ Initial Date of Coverage \_\_\_\_\_

**Dental Plan Coverage Elected:**

Employee Only (Employee Cost \$ \_\_)                       Employee + Spouse (Employee Cost \$ \_\_)

Employee + Child(ren) (Employee Cost \$ \_\_)                       Employee + Family (Employee Cost \$ \_\_)

Are you, your spouse or your dependent children covered under another dental benefits plan?     YES     NO

If yes, who is covered? \_\_\_\_\_

Name of insurance carrier for other coverage \_\_\_\_\_

**List your spouse and dependent children below who are to be enrolled:**

Last Name	First Name	Relationship To employee	Date of Birth	Social Security Number
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*Dependents eligible for coverage under this plan are defined as:*

1. Legal spouse of a covered employee.
2. Unmarried children to age \_\_\_\_\_ provided such children are dependent upon the employee for support and maintenance. College-age children shall be covered provided they are full-time students.
3. Children of a covered employee who have attained the age specified in paragraph 2 above, who are incapable of self-sustained employment due to a handicap of disability, and who are still dependent on the employee.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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Company Name  
**Direct Reimbursement Dental Benefits Plan**

**Description of Benefits**  
Effective ( date)

Direct reimbursement means what its name implies. (company name) reimburses employees directly for dental costs. No insurance is involved.

**How it works:**

- You and/or your covered dependent goes to the dentist of your choice and receives the treatment deemed necessary by both you (the patient) and your dentist.
- The patient is responsible for paying the dentist for treatment received.
- You then submit a receipt from the dentist to our claims administrator (The Benefit Companies). You will be reimbursed according to the following formula:

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There are no exclusions, waiting periods, or UCR values. All professional services provided to you by your dentist are covered under the above schedule. It is your responsibility to determine, with your dentist, his fees and services that are appropriate to your situation. Any discounts you negotiate will benefit you directly in that your annual benefit maximum will pay for more services.

(company name) is pleased to offer this **American Dental Association** and **Colorado Dental Association** sponsored program to our employees. We believe that it offers significant improvements to your dental benefit program and provides you with a direct relationship with your dentist, unencumbered by a third part intermediary.

Claim forms will be available form the HR office after (date).

**The Benefit Companies, L.L.C.**  
2696 South Colorado Blvd. #304, Denver, CO 80222  
(303)226-1000 or 1-800-530-2211 Fax: (303)226-1010  
Email: [CBGAdmin@benefitcompanies.com](mailto:CBGAdmin@benefitcompanies.com)