CDCS HEALTH CLAIMS INC.

PLAN DESIGN

Please Complete All Sections **GROUP #** _____

CLASSES - DIVISIONS/UNITS (use reverse side of this form if required)

Class Name and Number	Division/Units	Plan Design if different
_____	_____	_____
_____	_____	_____

COVERAGE: CLASS "___"	Basic Dental (includes Endo/Perio)	Major Restorative	Orthodontics
Reimbursement %	_____	_____	_____
Deductible	_____	_____	_____
Maximum	_____	_____	_____

MAXIMUM Calendar year _____ ***or*** Policy Year _____

Per Person _____ ***or*** Per Cardholder _____

COMBINED MAXIMUM Yes _____ No _____ Comments _____

LIFETIME MAXIMUM Yes _____ No _____ Comments _____

FEE GUIDE YEAR *(GP)* Current _____ Fixed at _____ /yr.

SPECIALIST FEES (_____%) Yes _____ No _____

COVERAGE: CLASS "___"	Basic Dental (includes Endo/Perio)	Major Restorative	Orthodontics
Reimbursement %	_____	_____	_____
Deductible	_____	_____	_____
Maximum	_____	_____	_____

MAXIMUM Calendar year _____ ***or*** Policy Year _____

Per Person _____ ***or*** Per Cardholder _____

COMBINED MAXIMUM Yes _____ No _____ Comments _____

LIFETIME MAXIMUM Yes _____ No _____ Comments _____

FEE GUIDE YEAR *(GP)* Current _____ Fixed at _____ /yr.

SPECIALIST FEES (_____%) Yes _____ No _____

Please Complete Reverse Side…

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Additional Information

Waiting Period _____ months. Applies to employees in the waiting period now? Yes_ No_____

Dependent unmarried children to their _____ birthday, or to their _____ birthday if attending a recognized educational institute or are mentally/physically infirm and dependent on the employee for support.

Termination age _____ or retirement, whichever is earlier.

Current Carrier _____ Is a copy of the wording/current codes and health plan enclosed?_____

CDCS to apply Co-ordination of Benefits guidelines to determine the order of benefits determinations and amounts payable? Yes_____ No_____

Special Concerns - please provide any information you feel may be necessary to establish your plan.

_____

_____

_____

_____

_____

CONTACT Name _____ Title _____

Telephone # _____ Facsimile # _____

E-Mail Address _____

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