

MISSISSIPPI DENTAL ASSOCIATION

Underwritten by:



BENEFIT FROM OUR DEDICATED SERVICE

**NIPPON LIFE INSURANCE
COMPANY OF AMERICA**
650 8th Street
Des Moines, Iowa 50309

11/06

**SPONSORED
MAJOR MEDICAL INSURANCE PLAN**

GROUP APPLICATION

REQUIRED FOR ALL GROUPS EMPLOYING 2 OR MORE FULL-TIME EMPLOYEES
Contact Total Plan Services, Inc. to determine specific application requirements for your group.

Upon completion, application must be signed, dated and returned to Total Plan Services, Inc. 14001 Dallas Parkway North, Suite 700, Dallas, Tx 75240

I. APPLICANT INFORMATION

NAME OF GROUP		TELEPHONE NUMBER	FAX NUMBER
GROUP ADDRESS (Street, City, State, Zip)			EMAIL ADDRESS
GROUP CONTACT	REQUESTED EFFECTIVE DATE	NUMBER OF FULL-TIME EMPLOYEES (minimum 20 hours/week)	
THIS REQUEST FOR INSURANCE IS TO REPLACE COVERAGE BY:		POLICY NUMBER	

II. MAJOR MEDICAL PLAN

BENEFIT OPTION SELECTION: Firms of two or more employees may select up to two benefit options or two deductibles per calendar year. Criteria for employee/deductible classifications are at the employer's discretion.

<input type="checkbox"/> HIGH DEDUCTIBLE HEALTH PLAN (Qualifies for use with an HSA) 100% In-Network 80% Out-of-Network <u>CALENDAR YEAR DEDUCTIBLE</u> Plan I: Individual <input type="checkbox"/> \$2,600 Plan I: Family <input type="checkbox"/> \$5,200 Aggregate Plan II: Individual <input type="checkbox"/> \$5,000 Plan II: Family <input type="checkbox"/> \$10,000 Aggregate	<input type="checkbox"/> HIGH DEDUCTIBLE HEALTH PLAN (Qualifies for use with an HSA) 80% In-Network 60% Out-of-Network <u>CALENDAR YEAR DEDUCTIBLE</u> Plan I: Individual <input type="checkbox"/> \$2,600 Plan I: Family <input type="checkbox"/> \$5,200 Aggregate	<input type="checkbox"/> PREMIER COPAY PLAN 80% In-Network 60% Out-of-Network <u>CALENDAR YEAR DEDUCTIBLE</u> Plan I: Individual <input type="checkbox"/> \$750 Plan II: Individual <input type="checkbox"/> \$1,000 Plan III: Individual <input type="checkbox"/> \$2,500	<input type="checkbox"/> BASIC COPAY PLAN 70% In-Network 50% Out-of-Network <u>CALENDAR YEAR DEDUCTIBLE</u> Plan I: Individual <input type="checkbox"/> \$750 / \$1,500 Plan II: Individual <input type="checkbox"/> \$1,000/\$2,000 Plan III: Individual <input type="checkbox"/> \$2,500/\$5,000
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- Select NETWORK DESIRED (applies to all employees and their dependents participating in your group plan): MPCN MHP / Healthlink PHCS
- Select EMPLOYEE ELIGIBILITY WAITING PERIOD: 30 DAYS 60 DAYS 90 DAYS OTHER _____
- PRIOR COVERAGE INFORMATION: Does this group currently have a group insurance plan for employees or did it have such a plan in the past 63 days?
 YES NO Termination date of prior plan: _____
- BILLING OPTIONS: Monthly draft (requires pre-authorized checking (PAC) form) Monthly Premium Notice

SPONSOR AGREEMENT

As a Sponsor under the Group Policy, issued by Nippon Life Insurance Company of America to the Mississippi Dental Association, the above named employer agrees to:

- Provide for the enrollment of employees eligible for group insurance under such policy;
- Provide information required by the Trust and the Benefit Services Manager (Total Plan Services, Inc.) with respect to employees requesting such insurance;
- Provide payroll deduction facilities for collection of any required contributions toward the premiums payable under such policy;
- Remit all amounts payable toward the premiums to Total Plan Services, Inc.;
- Maintain 75% participation of all eligible employees; and
- Sponsor will remain an active Association member working at least 30 hours per week.

It is understood that Nippon Life Insurance Company of America must approve this group's participation in the program and that all insurance shall be subject to the terms and conditions of the group policy.

Agreed to by:

GROUP NAME: _____ DATE: _____

AUTHORIZED SIGNATURE: _____ TITLE: _____

Please return this completed form to: Total Plan Services, Inc.
Phone: 1-800-969-5238

Plan Administrator
14001 Dallas Parkway North, Suite 700
Dallas, Tx 75240