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(800) 558-8003 ● www.calchoice.com

Voluntary Dental 3000 Group Application

Company Name

Group #

Authorized Group Contact

Phone # (XXX) XXX-XXXX

Broker Name

Broker #

Coverage Selection

Complete numbers 1 - 2 below

1. Requested effective date* (MM/DD/YYYY)
2. Total number of employees applying for Dental 3000 coverage

Benefit Information

EXAMS & DIAGNOSTICS	IN-NETWORK
Annual Maximum	Unlimited
Annual Deductible	No Deductible
Initial Oral Exam	No Charge
Periodic Oral Exam	No Charge
Teeth Cleaning	No Charge
Bite-Wing X-Ray	No Charge
ORAL SURGERY	
Removal of Uncomplicated Single Tooth	$ 10 Copay
Removal of Impacted Tooth - Partially Bony	$ 50 Copay
Removal of Impacted Tooth - Completely Bony	$ 65 Copay
RESTORATIVE	
Cavities - Amalgam, 1 surface	$ 9 Copay
Cavities - Amalgam, 2 surfaces	$ 14 Copay

ENDODONTICS	IN-NETWORK
Single Root Canal	$ 100 Copay
Bi-Root Canal	$ 135 Copay
Molar Root Canal	$ 185 Copay
PERIODONTICS	
Gingivectomy - per tooth	$ 15 Copay
Periodontal Scaling & Root Planing (quadrant)	$ 26 Copay
CROWNS	
Porcelain - Base Metal (posterior)	$ 225 Copay
Full Cast Noble Metal	$ 115 Copay
ORTHODONTICS	
Children (maximum age 18)	$ 1,600 Copay
Adult	$ 1,950 Copay
PROSTHETICS	
Complete Upper or Lower Denture	$ 120 Copay
Partial Upper or Lower Denture	$ 110 Copay

Guidelines and Requirements

- Employees not enrolled in medical must complete an enrollment application.
- Dependents not enrolled in medical must be included in Section 3 of the enrollment application.
- Voluntary Dental 3000 can be written simultaneously with Dentegra Smile Club.
- Voluntary Dental 3000 CANNOT be written as a dual option with any Employer Sponsored Dental Plan option.
- No participation requirements.
- No Employer contribution.
- Employees and dependents not enrolled when initially offered by Employer must wait until Renewal.
- *Dental coverage will be effective first of the month following receipt of this fully completed application, unless adding for renewal.

Employer Signature	Print Name	Date (MM/DD/YYYY)

Enrollment Information

Coverage Codes: **EE** = Employee Only **ES** = Employee & Spouse **EF** = Employee & Family **EC** = Employee & Children

	Employee's Full Name		Coverage Code	Dentist Name/Office	Dentist I.D. #	Employee Signature
Example:	**John**	**Smith**	☐ EE ☒ ES ☐ EF ☐ EC	**Bill Jones**	**00-DP65**	John Smith
1.			☐ EE ☐ ES ☐ EF ☐ EC			
2.			☐ EE ☐ ES ☐ EF ☐ EC			
3.			☐ EE ☐ ES ☐ EF ☐ EC			
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24.			☐ EE ☐ ES ☐ EF ☐ EC			
25.			☐ EE ☐ ES ☐ EF ☐ EC			

Please make a photocopy if additional forms are necessary