

Direct Reimbursement Small Group Set-up Guide

In order to prepare your Direct Reimbursement Dental Plan, please fill in the following information. Do not leave any blanks.

Company Info:

Company Name: _____

Owner or Authorized person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:(_____) _____ Fax:(_____) _____

Tax ID#: _____

Effective Date of Plan: _____

Plan Info:

Annual Maximum Benefit: Per person:\$ _____ Per Family:\$ _____
(For example: \$1000 per person/ \$2500 per family)

Copayment Level: Company: _____ % Employee: _____ %
 Company: _____ % Employee: _____ %
(For example: Company 80%, Employee 20%....Company 50%, Employee 50%)

Orthodontia Coverage: Yes No

Employee must work _____ hours per week to qualify for the plan.

New Employees must complete _____ (Days,Months,Years) to be eligible. (Maximum 3 Years)

Dependents: will will not, be covered.

Claims:

Claims should be sent to: (If different than above)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employee Census Data:

_____ Singles _____ Employee & Spouse _____ Employee & Child(ren) _____ Family

Please return with check for **\$350.00** to:

Direct Reimbursement Dental Plans of NY, Inc.
88 Sunnyside Blvd. Suite 203
Plainview, NY 11803
(516) 349-1890