



# MADA

## MADA DENTAL PLAN

### GROUP ENROLLMENT FORM

FAX TO: (573) 636-5834

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

Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: \_\_\_\_\_

\_\_\_\_\_

Fax Number: \_\_\_\_\_

\_\_\_\_\_

Requested Effective Date: \_\_\_\_\_

Total No. Eligible Full-Time Employees: \_\_\_\_\_ Total No. Enrolling: \_\_\_\_\_

Will this plan replace an existing plan? \_\_\_\_\_

Will this plan be offered in addition to an existing plan? \_\_\_\_\_

Employer Contribution \_\_\_\_\_% Gold Employer Contribution \_\_\_\_\_% Platinum

#### Group Eligibility Waiting Period:

1<sup>st</sup> of month following date of employment

1<sup>st</sup> of month following **30** days of employment

1<sup>st</sup> of month following **60** days of employment

1<sup>st</sup> of month following **90** days of employment

1<sup>st</sup> of month following **180** days of employment

**Waive Eligibility Waiting Period for All Existing Employees**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

#### For Office Use Only:

Benefit Wait Period Code: \_\_\_\_\_

DIV#: \_\_\_\_\_

1. Normal waiting period applies (3,6,12 months).
2. No wait, existing plan.
3. No wait, employer paid.