Direct Reimbursement Dental Benefit Plan

Cost Estimation Data Sheet

Section I: General Information

Group Name:_____ Contact:_____

Address:_____City:_____State:____Zip:_____

Telephone:_____ Fax:_____

Are all employees Located at the above address? Yes____ No____
If no, city/state/zip/# of employees at each site:

_____

_____

Current dental benefits offered: Yes____ No____
If yes, expiration/renewal date: ___/___/_____

Section II: Direct Reimbursement Plan Designs to be calculated

Check the desired plan design(s) below:

- ❑ 100% of $100; 80% of next $200; 50% to max. $1000(Standard)
- ❑ 100% of $200; 80% to max. $1000
- ❑ 100% of $200; 80% of $500; 50% to max. $1500
- ❑ ____% of $____; _____% of $_____; _____% of $_____; to max. $_____

Section III: Employee Breakdown

Proposed effective date of Direct Reimbursement program: _____/_____/_____

Total# employees:_____(Single_____,Emp+Spouse_____,Emp+Children_____,Family_____)

Will employee contributions be required? Yes_____ No_____
If yes, please indicate how costs will be shared:
Employee Coverage: Employee pays _____%, Employer pays _____%
Dependent Coverage: Employee pays _____%, Employer pays _____%

Please fax back to:

Direct Reimbursement Dental Plans of NY, Inc.
Fax (516) 349-1891