



Rayant Insurance Company of New York
 Rayant Insurance Company of Pennsylvania
 Horizon Companies

Send Correspondence to:
 Rayant - Dental Programs
 P.O. Box 1938
 Newark, NJ 07101-1938
 1-888-667-4547
 www.rayant.com

Group Application for 51 + Employees

Group Number _____

Company Name: _____ Effective Date: _____

Primary Location: _____
Street City State Zip

Telephone Number: (____) _____ Fax Number: (____) _____ SIC Code (4-Digit): _____

Type of Industry: _____ ID Cards Mailed to: Group Employee's Home

Company Official: Name _____ Title: _____ Phone#: _____

Billing Contact: Name _____ Title: _____ Phone#: _____

Number of Employees: Eligible _____ Enrolled in Plan _____

Employer Contribution: Employee _____ H/W _____ DP _____ Family _____ P/C _____

Dependent Child(ren) covered to age: _____ (eom/eoy) Full-time Students covered to age: _____ (eom/eoy)

Probationary Period and Effective Date:

New Hires: Date of Hire _____ # of Months _____ Effective Date 1st of month following
 Exact Date
 Other _____

Rehires: Date of Hire _____ Same as New Other _____

Termination of Employee: Exact Date End of Month

Class of Eligible Employees: (Check all that apply.)

Full Time/# Hours per week _____ Permanent Part Time/# hours per Week _____

Salaried _____ and/or Hourly _____

Union Affiliation: Yes, Local # _____ No

Current Carrier Replaced: _____

1. Is Rayant's Internet maintenance for enrollment of interest to you?: Yes No

2. If yes, please provide email address for Internet contract: _____

3. Who will administer COBRA?: Group COBRA Elect Other _____

4. Are retirees eligible for dental benefits?: Yes Required minimum number of years worked: _____ No

5. Amount of advanced check, if any: \$ _____ Check #: _____

Agent/Producer Information (This information must be answered completely.)

Broker Signature: _____ Date: _____ Vendor Number: _____

Broker Name: _____ Name of Agency: _____

Telephone Number: (____) _____ Fax: (____) _____ E-mail Address: _____

Address: _____
Street City State Zip

Others: Name _____ Title _____

Special Instructions: _____

Company Name: _____

Address: _____
Street City State Zip

Company Official's Signature _____ Date _____

I authorize the aforementioned Commissioned Broker to be the Broker of Record for our health insurance. This contract will be valid until Rayant is notified in writing to cancel. Commissions should be paid to our company's Broker of Record beginning on our effective/anniversary date.