



APPLICATION FOR BROOKLYN HEALTHWORKS DENTAL & VISION PLAN OPTIONS

Brooklyn HealthWorks Group Name: _____

Brooklyn HealthWorks Group Number: _____

Desired Effective Date: _____

THIS APPLICATION MUST BE SUBMITTED WHEN A GROUP INITIALLY ENROLLS IN BROOKLYN HEALTHWORKS OR DURING THE GROUP'S ANNUAL RENEWAL PERIOD.

Monthly Premiums*

Tier	Preferred Dental & Vision Plan	Premier Dental & Vision Plan
Individual Employee	\$18.07	\$39.11
Employee & Spouse/Domestic Partner	\$34.83	\$75.54
Employee & Child(ren)	\$39.80	\$88.42
Family	\$55.65	\$126.14

**Rates are guaranteed for a period of twelve months from the effective date of enrollment.
Rates will be 2% higher for COBRA enrollees.*

Subscribers Enrolling in Brooklyn HealthWorks Dental & Vision Plans

The employees on page 2 of this application are enrolling in Brooklyn HealthWorks dental and vision plan options and were notified they will not be able to make changes to their plan selection (including dropping coverage) for at least 12 months and only during your group's annual medical renewal period. Each employee enrolling has also received a copy of Brooklyn HealthWorks dental and vision 1) summary of benefits, and 2) plan description.

Initials of authorized officer: _____

Employees Enrolling in Brooklyn HealthWorks Dental & Vision Plan Options

Subscriber Name (please print) [Subscriber dependents enrolled in Brooklyn HealthWorks will also be enrolled.]	Subscriber Number (Employee GHI ID number)	Enrolling in Preferred Plan (check here)	Preferred Plan Primary Care Dentist Code (list code here or a dentist will be assigned to you)	Enrolling in Premier Plan (check here)	Has subscriber and dependents had at least 12 months of continuous dental coverage? Yes/No

Please copy this page if you need more space.

Subscribers NOT Enrolling in Dental & Vision Plans

All other employees with Brooklyn HealthWorks coverage were informed about the option to enroll in new dental and vision plan options offered by Brooklyn HealthWorks, are waiving coverage at this time, and understand they will not be able to enroll again until your annual medical renewal period.

Initials of authorized officer: _____

Print name of officer completing application: _____

Signature of officer completing application: _____

Title: _____

Date: _____

You may submit this application by:

1. Scanning this document and e-mailing it to dmohs@brooklynchamber.com
2. Faxing a copy to 718-643-9707