OFF-EXCHANGE DENTAL CARRIER APPLICATION (v.01)

FOR CERTIFICATION BY MARYLAND HEALTH BENEFIT EXCHANGE

Instructions:

This form is required for Off-Exchange Stand-Alone Dental (O-SADP) Carriers seeking Maryland Health Benefit Exchange certification for their plans. The O-SADP applicant, hereafter Applicant, is required to complete sections 1-2. If additional space is needed to respond, please add pages as necessary.

Please provide the following information:

Section 1 – Carrier Information

Carrier/Issuer's Legal Name: _____

Doing Business As (if applicable):_____

NAIC Number: _____

Date Maryland Licensure Received: _____

Expiration Date of Maryland License: _____

Federal Employer Identification Number: _____

Accreditation Status: _____

Address: _____

City/State/Zip: _____

Submitter's Contact Information

Submitter's Name: _____

Submitter's Phone Number: _____

Submitter's E-mail: _____

Section 2 – Product Information

Off-Exchange Dental Product Information:

SERFF Tracking Number(s):	********
Form Number:	********
Plan Name(s):	Sample Plan 1
Tier(s):	Low vs. High (70% or 85% Actuarial Value)
Coverage level:	Pediatric, Family, Adult, etc.
Product Type(s):	DPPO, DHMO, etc.
Participating Market:	Individual/Small Group
Service Areas(s):	Counties, Zip Codes, Whole-state

✸In lieu of completing this portion, Applicant may provide an excel (.xls) spreadsheet with the above plan information or an attached list of approved forms with date of approval and applicable SERFF tracking number for each form.

I hereby certify to the Maryland Health Benefit Exchange (MHBE) that the above-listed organization is:

(Check One)

_____ Licensed in the State of Maryland as a risk bearing entity

or

_____ Authorized to operate as a risk bearing entity in the state of Maryland.

With the submission of this application, the Applicant attests that it is in receipt of notice from the Maryland Insurance Administration that its products have been approved as meeting the requirements specified in §31-115(l)(1) of the Insurance Article of the Annotated Code of Maryland.

_____ _____

Date (Applicant)

_____

Signature of Submitter authorized to execute document on behalf of Applicant

_____

(Title)

The Maryland Health Benefit Exchange (MHBE) completes section 3

Section 3.

State official reviewing the QHP or o-SADP certification request:

MHBE Reviewer's Name: _____

Agency Name: _____

Address: _____

City/State: _____

Telephone: _____

Email Address: _____