Self-Funded Dental /Vision Reimbursement Plan
Set-Up Form

Group Name: ____ **Total Employed: _____________**

ASI Effective Date: ____________________

Dental ☐ **Vision** ☐

If a change to an existing plan administered by ASI, check below and complete benefit summary on the following pages, sign on the last page and return to ASI.

Change to current plan ☐ Effective date of change in benefits: __________________________

Plan Document:

Is ASI to prepare a plan document? ☐ Yes ☐ No
If you have an existing plan, please include a copy of your current plan document.

Enrollment:

Do your employee have the option of enrolling separately in either the dental or vision plan? ☐ Yes ☐ No

Banking Options: Please check option that you want for the administration.

☐ A voided check must be sent to ASI before any claims can be paid. All checks will be prepared on the employer's account, produced by ASI. These checks will be sent to the employer to sign and forward to the provider of services being provided. Please attach a voided check and indicate the starting check number. **Check starting # __________**

☐ ASI opens a separate account for the benefit of the client. ASI prepares the checks then notifies the client of the check run and amount. Client may pre-fund account or fund each check run as provided by ASI. ASI signs, then forwards checks to the provider of service or employee. There is an administration fee from the bank of $25.00 per month. This fee is currently being waived by the bank we utilize. If the bank should require a monthly fee in the future, ASI will pass the cost to the client. **Check in the amount of $ _________ is attached.**

Benefit Summary

Self-Funded Dental

Deductible: Individual $ __________ Family $ ___________ Per Member $ _____________

Deductible Waived for Diagnostic & Preventive: ☐ Yes ☐ No

Annual Maximum Benefit for each member: $__________________

Diagnostic & Preventive _____________% In Network __________% Out of Network

Basic _____________% In Network __________% Out of Network

Major _____________% In Network __________% Out of Network

Prosthodontic _____________% In Network __________% Out of Network

Orthodontia _____________% In Network __________% Out of Network

Ortho Annual Maximum $ _________________ Ortho Lifetime Maximum $ _________________

Ortho applies to: ☐ Children to age 18 ☐ All Members

Network: ☐ Yes If yes, what network: ____

☐ No If no, UCR will be applied: ____

Self-Funded Vision

Deductible: Individual $ __________ Family $ ___________ Per Member $ _____________

Deductible Waived for Exam Only: ☐ Yes ☐ No

Annual Maximum Benefit for each member: $__________________

Exam ____________% or Co-pay __________ Frequency

Material ____________% or Co-pay __________ Frequency

Frame ____________% or Co-pay __________ Frequency

Lens ____________% or Co-pay __________ Frequency

Contacts ____________% or Co-pay __________ Frequency

Contacts in lieu of Lens: ☐ Yes ☐ No

Contacts Annual Maximum for each member $ _________________

I agree that the attached schedule of benefits drafted for our plan and the fees listed in this set-up form are correct and accurate.

Completed By: ______________________________ **Title:** ________________________________

Once ASI receives all the information on the set up of the group, we will send a welcome kit out to the group contact. This will include forms to utilize during the year, administrative agreement, department contact list and the plan document if ASI prepares it.

ASI Internal Use Only:

Implementation Fees: _________
Per Participant/Per Month: _________
Broker Commission: ________
Network Fee: _______
Annual Fee: ________
Other: ________