

GSA ATTACHMENT 1

ACKNOWLEDGEMENT OF RECEIPT Healthcare Group of Arizona Dental Plans

On behalf of the undersigned employer group, I acknowledge that I have received and read the Enrollment and Coverage Booklet (EDS 700R) supplied by Employers Dental Services (EDS) and the Dental PPO Benefit Summary supplied by Principal Life. The undersigned employer group is acting on its own behalf and on behalf of its eligible employees and their dependents who enroll for dental coverage.

Terms of Agreement

Dental coverage through the EDS Dental HMO Plan and the Principal Plan Dental PPO shall take effect on the employer group's contract effective date for medical benefits and shall remain in effect for a term of one year. Dental benefits cannot be terminated independent of the employer group's medical benefits. Dental coverage is renewable each year provided Healthcare Group Administration (HCGA) has verified that the employer group remains eligible for the Healthcare Group (HCG) program, and the employer group renews medical coverage.

(please initial)

_____ I am aware that HCG's dental HMO plan is provided by Employers Dental Services and HCG's dental PPO plan is provided by Principal Life.

_____ I am aware that dental benefits are subject to the limitations and exclusions set forth in EDS' Enrollment and Coverage Booklet 700R and Healthcare Group's Principal Plan Dental PPO Benefit Summary.

_____ I am aware that dental benefits are subject to the governing conditions and provisions of the HCG program as set forth in the Group Service Agreement.

_____ I am aware that grievances and appeals related to dental benefits are subject to the HCG appeal process as set forth in the HCG Group Service Agreement and Member Handbook.

_____ I am aware that dental benefits run on the same contract cycle as the employer group's medical benefits and cannot be terminated independently.

Acceptance

By signing this acknowledgement, the undersigned parties agree to all terms and conditions contained in the coverage documents mentioned above, including any and all attachments.

Healthcare Group of Arizona

10851 N. Black Canyon Hwy, Suite 660

Phoenix, AZ 85029

602.417.6755

Group Name

Group Number

Group Address

City, State, Zip

By: _____
HCG Authorized Signature

By: _____
Employer Group Authorized Signature

Print Name: _____

Print Name: _____

Date: _____

Date: _____