

GENERAL INFORMATION FOR DENTAL PLAN QUOTATION

Group Name: _____

Type of Industry: _____

Years in the Market: _____

EMPLOYEE DISTRIBUTION		
Individual: _____	COBRA: _____	
Couple: _____	Optional: _____	
Familiar: _____		
Total Eligible Employees: _____ (same as medical plan)		
Employer Contribution: <input type="checkbox"/> NO <input type="checkbox"/> YES How much? _____ %		
Actual Carrier: _____		
Effective Date: _____		
Actual Fees:		
Individual: \$ _____	Couple: \$ _____	Familiar: \$ _____
Renewal Fees:		
Individual: \$ _____	Couple: \$ _____	Familiar: \$ _____

ACTUAL DENTAL COVERAGE	DENTAL COVERAGE TO BE QUOTED	
Diagnostic & Preventive _____ %	Diagnostic & Preventive _____ %	_____ %
Basic Restorative Services _____ %	Basic Restorative Services _____ %	_____ %
Crowns & Prosthodontics _____ %	Crowns & Prosthodontics _____ %	_____ %
Orthodontics Services _____ %	Orthodontics Services _____ %	_____ %
Annual Maximum \$ _____	Annual Maximum \$ _____	\$ _____
Orthodontics Maximum \$ _____	Orthodontics Maximum \$ _____	\$ _____

Agent / Broker Information

Name: _____

Company: _____

Phone: _____

Fax: _____

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