



Employer Dental Plan Selection

Please use this form to record the dental plan options you select. The form allows you to record up to four plan options. If you select more than that, please make additional copies as needed. When completed, **securely email** them to MNsure_SHOP@state.mn.us. If you need a secure email to which you can attach the document, please request one from the same email address. If you do not have scanning capabilities, please mail the documents to the address below. You will receive e-mail confirmation of receipt of the documents. Thank you.

MNsure SHOP - Dental
P.O. Box 64246
St. Paul, MN 55164-0246

Please complete all the information requested below.

Company Name:	
Doing Business As: (if applicable)	
Company Address:	
Contact Name:	
Contact Phone Number:	
Contact E-mail Address:	
Company FEIN: (i.e. Tax ID Number)	
Broker Name: (if applicable)	
Broker E-mail:	
Broker Phone Number:	

IMPORTANT: You will receive e-mail confirmation when MNsure has received this form. It will include a communication that you can give to your employees to guide them through the review and selection process. After they complete and sign the Employee Dental Plan Selection form and/or the Employee Application, please collect the documents and return them to MNsure via secure email.



Employer Dental Plan Selection

Dental Employer Enrollment Selection | Contribution Amount & Plan Selection

If you offer dental benefits to your employees, you can decide if you will offer one plan or a choice of plans. You will select an effective date and decide what your contribution percentage will be for both employees and dependents. There are no minimum contribution requirements for dental.

Effective Date: _____

Employer Contribution for Employees: _____

Employer Contribution for Dependents: _____

Please note your dental plan selections below. The Dental Plan Name and Product ID# is found on the 'Dental Plan Rates and Benefits Summary' documents. The Product ID# can be found at the bottom of the rate grid on the left side (example below).

Age	Individual Monthly Rate
0-18	\$XX.XX
19-64	\$XX.XX

(Product ID# 26825MN0180001-01) ←

Dental Plan Name & ID Number: _____

Read & Sign this Enrollment

- I have provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal and state law if I intentionally provide false or untrue information.
- This is my dental insurance election.

Company Name (please print)

Employer/Contact Name (please print)

Employer/Contact Signature

Date (mm/dd/yyyy)