Provider Credentialing Application

Complete all pages of this application

GENERAL INFORMATION (please print or type)

Name_____Degree o DMD o DDS

Specialty_____Social Security #_____Date of Birth_____Gender o M o F

(For internal use only)

Status: Owner DDS_____Partner_____Employee DDS_____IndependentContractor _____

MA number_____Type I NPI_____Type II NPI_____

LICENSING INFORMATION

Please provide complete information for all states in which you are currently licensed, and include copies of your State license and DEA Registration

DDS License #_____State_____DDS License #_____State_____

D.E.A. Registration Number_____Date of Issue_____Expires _____

PRIMARY PRACTICE PROFILE

Name of Practice/Corporation _____

TIN _____

Street Address _____

City_____County_____State_____Zip_____

Phone: Day_____After Hours_____Fax_____

Web Address_____E-Mail_____

Typeof Practice: Solo_Partnership_Group If Group Practice, Number of Dentists in Practice _____

Are you open to new patients?_Yes_No

Please include a separate application for each dentist applying for participation

* If you have more than one location complete the additional location page*

BILLING ADDRESS (if different from street address)

Name_____

Street Address _____

City_____County_____State_____Zip _____

LIABILITY COVERAGE INFORMATION

Professional Liability Carrier_____Expires_____

Per Case $_____Aggregate $_____Is Policy:_____Claims Based_____Occurrence Based

If Claims Based, Do You Have Tail Coverage? _____

List Any Other Malpractice Carriers Who May Have Carried Insurance On You In The Last Five Years:

Name_____Address_____

Name_____Address_____

General Liability Carrier_____Expires_____

Agent Name_____Agency Phone _____

Policy Number_____Per Case $_____Aggregate $ _____

Please include copies of your insurance coverage certificates

2323 Grand Blvd Kansas City, MO 64108 □ 1-800-392-3112 □ Fax 763-559-8389 □ www.premier-dental.com □networksupport@sunlife.com

EDUCATION, EXPERIENCE, QUALIFICATIONS

Pre-Dental Education (collegeor university)_____Degree Received _____
City_____State_____Country_____Major_____
Dental Education (collegeor university)_____Degree Received _____
City_____State_____Country_____Grad. Date _____
Additional Training (institution) _____
(Include specialty education, internships, residencies, fellowships)
Address_____City_____State_____
Number of Years_____From_____To_____Institution_____
Address_____City_____State_____
Number of Years_____From_____To_____

Board Certified_____Yes____No

If Certified,	Certifying Board	Date of Certification	Expires
	_____	_____	_____
	_____	_____	_____

SPECIALISTS—please include one or more of the following.
o SpecialtyLicense o SpecialtyCertification o Educationalproofof specialty training
Hospital Staff Privileges (if any) o N/A
1) Hospital_____Status_____Date_____
Address _____
2) Hospital_____Status_____Date_____
Address _____

PRACTICE HISTORY

Please provide a chronological listing of clinic/practice history for the last 5 years. If there is a gap of 3 months or more between clinics you must provide an explanation. Please use separate sheet if necessary.

From (mth/yr)	To (mth/yr)	Practice Name and Address	Position
_____	_____	_____	
_____	_____	_____	_____
_____	_____	_____	_____

Membership in Dental Societies and Organizations _____
_____
Dental School Teaching Positions Held_____
_____

REFRENCES

Please list names and addresses of two dentists who are not currently professional associates or partners authoritatively about your current professional qualifications.

Name	Address	Phone
Name	Address	Phone

PROFESSIONAL LICENSURE/MALPRACTICE HISTORY

For any "yes" answer, please attach a full explanation on a separate sheet.

1. Has your license and authority to practice in any jurisdiction, whether completed or still pending, been denied, restricted, limited, suspended, revoked, not renewed; or have you ever been placed under probation, subjected to disciplinary action, or otherwise sanctioned, limited or curtailed? Yes___No___

2. Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed? Yes___No___

3. Have you ever been convicted of a felony, or are felony proceedings, indictments or information presently pending? Yes___No___

4. Are you currently using illegal drugs? *("currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice dentistry. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22 It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other Provision of Federal law." The term does include, however, the unlawful use of prescription controlled Substances.)* Yes___No___

5. Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients or interfere with your ability to practice dentistry without posing a health or safety risk to your patients? If yes, what accommodation would help you provide appropriate care to patients and perform other essential functions? Yes___No___

6. Have you had any malpractice or other professional liability judgments or out-of-court settlements in the past 10 years; or do you have any malpractice or other professional liability claims currently pending against you, whether a formal notice of claim or lawsuit? *(Attach full explanation)* Yes___No___

7. Have you ever been sanctioned by or the subject of any professional censure or disciplinary action by a local dental society or peer review body? Yes___No___

8. Have you ever been refused membership or has your membership ever been revoked, suspended, or limited in a clinical facility, group practice, or in a managed care plan/network? Yes___No___

9. Has your board certification or a hospital privilege ever been revoked, suspended or restricted? Yes___No___

10. Have you ever been terminated for cause from any dental plan or managed care network? Yes___No___

11. Has your membership in any local, state or national professional society or organization ever been revoked or suspended, or are revocation or suspension proceedings presently pending, or have you ever been denied membership or renewal thereof in any such society or organization? Yes___No___

12. Have you ever been or are you presently the subject of an investigation by any state or federal agency or third party payor regarding your professional activities? Yes___No___

13. Has your Drug Enforcement Agency controlled substance authorization or other authorization ever been denied, revoked, suspended, reduced or not renewed, or have proceedings toward any of those ends ever been instituted, or are proceedings toward any of the ends presently pending? Yes___No___

I HEREBY AUTHORIZE the release of any information requested by Premier Dental Group from any person or entity. I hereby release from liability for their statements given or information furnished, all persons who submit information concerning my dental qualifications. I consent to the release of information for the purposes of proper evaluation by Premier Dental Group of professional competence, character, ethics and other qualifications.

A photocopy of permission will serve as the original. I understand that Premier Dental Group will use this information in confidence solely in conjunction with my application to affiliate with Premier Dental Group.

Signature of Dentist _____ Date _____

PATIENT ACCESS AND OFFICE INFORMATION

Number of dentists on staff_# of hygienists_# of RDAs__# of Assistants_# of Clerical staff

Scheduled Office Hours:

Monday_____Tuesday_____Wednesday_____Thursday_____Friday_____Saturday_____

What is your practice's currently daily patient load? Dentist_____Hygienist_____

What is your practice's current maximum daily capacity? Dentist_____Hygienist_____

What is your current waiting time for new patient appointments? Dentist_____Hygienist_____

What is your current waiting time for emergencies? Dentist _____

Number of availabletreatment rooms/areas_____Number of available hygiene rooms/areas _____

Are you currently participating in any other managed care plans or networks? YES NO____

If "yes". How many? _____

Briefly describe you after-hours emergency coverage and process: _____

_____

OTHER INFORMATION

Non-English Languages Spoken: o Spanish, o Somali, o German, o Hmong, o Vietnamese, o French, o Russian, Other_____Is anyone trained in Sign Language? YES____NO_____

Sovereign Community Provider YES____NO_____

Other Essential Community Provider (ECP) YES____NO_____

SAFETY AND HEALTH

Are you, or is your staff, certified in CPR? YES____NO_____

Is an emergency medical kit available and routinely updated? YES____NO_____

Are your hazardous waste procedures in accordance with state and local laws? YES____NO_____

Do you and your staff utilize proper infection control standards? YES____NO _____

Does your radiography equipment and procedures meet with government regulated standards andADA recommendations? YES____NO_____

PATIENT CONVENIENCE-

Is your buildinghandicapped accessible? YES_____NO____ Handicap parking YES____NO_____

Is your office Handicapped accessible? YES____NO_____ Handicap restroom YES___NO____

Handicap equipment YES____NO____ Handicapped exam room YES___NO_____

Do you visit homebound or extended care facility patients? YES____NO_____

ENCLOSE A COPY OF THE FOLLOWING with this completed

o application: Currentstate(s) license(s)

o Current DEA certificate (if applicable)

o Current malpractice certificate of coverage

o Specialty Board Certificate (if applicable) or proof of completion of specialty education

I understand that, subject to proper confidentiality restrictions and authorizations, my office dental records will be subject to inspection by Premier Dental Group for quality assurance and utilization review purposes. I hereby certify that the information contained on this application is correct & complete. I understand that any information entered into this application which subsequently is found to be false could result in a termination of contract.

Signature_____Date _____

ADDITIONAL LOCATION(s) Under the same TIN
Name of Practice _____
Street Address _____
City_____County_____State_____Zip_____
Phone: Day_____After Hours_____Fax_____Web address__
_____E-Mail _____

PATIENT ACCESS AND OFFICE INFORMATION
Number of dentists on staff_# of hygienists_# of RDAs__# of Assistants_# of Clerical staff
Scheduled Office Hours:
Monday_____Tuesday_____Wednesday_____Thursday_____Friday_____Saturday_____
What is your practice's currently daily patient load? Dentist_____Hygienist_____
What is your practice's current maximum daily capacity? Dentist_____Hygienist_____
What is your current waiting time for new patient appointments? Dentist_____Hygienist_____
What is your current waiting time for emergencies? Dentist _____
Number of availabletreatment rooms/areas_____Number of available hygiene rooms/areas _____

ADDITIONAL LOCATION(s) Under the same TIN
Name of Practice _____
Street Address _____
City_____County_____State_____Zip_____
Phone: Day_____After Hours_____Fax_____Web address__
_____E-Mail _____

PATIENT ACCESS AND OFFICE INFORMATION
Number of dentists on staff_# of hygienists_# of RDAs__# of Assistants_# of Clerical staff
Scheduled Office Hours:
Monday_____Tuesday_____Wednesday_____Thursday_____Friday_____Saturday_____
What is your practice's currently daily patient load? Dentist_____Hygienist_____
What is your practice's current maximum daily capacity? Dentist_____Hygienist_____
What is your current waiting time for new patient appointments? Dentist_____Hygienist_____
What is your current waiting time for emergencies? Dentist _____
Number of availabletreatment rooms/areas_____Number of available hygiene rooms/areas _____

ADDITIONAL LOCATION(s) Under the same TIN
Name of Practice _____
Street Address _____
City_____County_____State_____Zip_____
Phone: Day_____After Hours_____Fax_____
Web address_____E-Mail _____

PATIENT ACCESS AND OFFICE INFORMATION
Number of dentists on staff_# of hygienists_# of RDAs__# of Assistants_# of Clerical staff
Scheduled Office Hours:
Monday_____Tuesday_____Wednesday_____Thursday_____Friday_____Saturday_____
What is your practice's currently daily patient load? Dentist_____Hygienist_____
What is your practice's current maximum daily capacity? Dentist_____Hygienist_____
What is your current waiting time for new patient appointments? Dentist_____Hygienist_____
What is your current waiting time for emergencies? Dentist _____
Number of availabletreatment rooms/areas_____Number of available hygiene rooms/areas _____

Please copy for any additional locations

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

THE PREMIER DENTAL GROUP, INC.
PROVIDER PARTICIPATION AGREEMENT

THIS AGREEMENT, effective _____ ("Effective Date"), is made between The Premier Dental Group, Inc. ("Premier") and:

_____ ("Provider"), an individual; or _____ ("Dental Group") and Dental Group Providers (Dental Group and Dental Group Providers are individually and collectively referred to as "Provider") for the purpose of setting forth the terms and conditions under which Provider shall render dental care services to individuals covered by benefit plans sponsored or issued by Sponsors, as defined in this Agreement. For services rendered on or after its Effective Date, this Agreement supersedes and replaces any existing agreements between the parties relating to the same subject matter.

SECTION 1
Definitions

Benefit Contract: A benefit plan which is for or includes dental care coverage, is sponsored or issued by a Sponsor, and contains the terms and conditions of a Covered Person's coverage.

Copayment: The amount a Covered Person is required to pay for certain Dental Services in accordance with the Covered Person's Benefit Contract.

Covered Person: An individual who is properly enrolled for coverage under a Benefit Contract.

Customary Charge: The reasonable and customary fees charged by Provider which do not exceed the fees Provider would charge any other person regardless of whether the person is a Covered Person.

Deductible: The annual amount of charges for Dental Services, as provided in the Covered Person's Benefit Contract, which the Covered Person is required to pay.

Dental Group Provider: A doctor of dentistry licensed and qualified in the state of _____ who practices as a shareholder, partner or employee of Dental Group, and who is listed on the attached Exhibit 1, which may be modified from time to time upon written mutual consent of the parties.

Dental Services: The dental care services and supplies covered by the Covered Person's Benefit Contract.

Emergency: A sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to jeopardize the Covered Person's life, cause serious impairment in bodily functions, or cause serious and permanent dysfunction of any bodily organ or part.

Fee Maximums: The maximum fees for Dental Services rendered by Premier Providers, as determined from time to time by Premier.

Necessary and Appropriate: Dental services that, in Premier opinion, satisfies all of the following criteria:

(1) It is medically required and medically appropriate for the diagnosis and treatment of the Covered Person's illness or injury;
(2) It is consistent with professionally recognized standards of care; and
(3) It does not involve costs that are excessive in comparison with alternative services that would be effective for the diagnosis and treatment of the Covered Person's illness or injury.

The fact that a health care provider may have prescribed, ordered, recommended or approved the provision of certain services or supplies to the Covered Person does not necessarily mean that such services or supplies satisfy the above criteria.

Premier Provider: A health care professional or facility, including Provider, that has a participation agreement in effect with Premier to provide Dental Services to Covered Persons.

Sponsor: The entity or person authorized by Premier to access all or a portion of Premier's network of Premier Providers, and has the financial responsibility for payment of Dental Services covered by that Sponsor's Benefit Contracts (i.e., a self-insured employer).

SECTION 2
Covered Person Eligibility for Dental Services

Section 2.1 Identification Cards. Sponsor, Premier or their designee shall give Covered Persons identification cards which shall bear the name of the Covered Person and his or her identification number.

Section 2.2 Verification of Eligibility. Provider may verify the current status of the Covered Person's eligibility for Dental Services by requesting presentation by the Covered Person of his or her identification card or by contacting Sponsor, or their designee during normal office hours in accordance with the Provider Manual. However, if Sponsor subsequently determines that the individual was not eligible for coverage for the services rendered, those services shall not be eligible for payment. Provider may then directly bill the individual for such services.

SECTION 3
Provision of Dental Services

Section 3.1 Provision of Dental Services. Provider shall provide Necessary and Appropriate Dental Services to all Covered Persons as recommended by Premier, in a timely, prompt and efficient manner consistent with the standard of practice of the community in which Provider renders Dental Services. Provider shall provide Dental Services to all Covered Persons as Provider's patient load and appointment calendar permit and shall accept Covered Persons as new patients on the same basis as Provider is accepting non-Covered Persons as new patients without regard to race, religion, sex, color, national origin, age or physical or mental health status. Provider shall be bound by the Premier Provider Manual and credentialing criteria, as modified from time to time by Premier. Failure to comply with the protocols and standards of Premier may result in loss of reimbursement to Provider and/or termination of this Agreement.

Section 3.2 Utilization Management and Quality Assurance. Provider shall cooperate with all utilization management, quality assurance, peer review, Covered Person grievance, or other similar programs established by Premier.

Section 3.3 Provision of Dental Services by all Dental Group Providers in Dental Group. Acceptance of Provider as a Premier Provider is subject to the requirement that, at Premier's discretion, all providers in the Dental Group become Premier Providers. However, Provider understands that all providers in the Dental Group must go through the Premier credentialing process before they are accepted as Premier Providers. Provider also understands that Dental Group Providers may be individually terminated as Premier Providers pursuant to Section 11.5 of this Agreement.

SECTION 4
Payment for Dental Services

Section 4.1 Payment for Dental Services. Sponsor shall pay Provider for Necessary and Appropriate Dental Services rendered to a Covered Person the lesser of (1) Provider's Customary Charge for such Dental Services, less any applicable Copayments and Deductibles; or (2) the Fee Maximum for such Dental Services, less any applicable Copayments and Deductibles. The obligation for payment under this Agreement for Dental Services rendered to a Covered Person is solely that of Sponsor, although Premier may provide or arrange for claims processing services.

Section 4.2 Submission of and Adjustments to Claims for Dental Services. Provider shall submit claims for Dental Services in a manner and format described in the Provider Manual.

Section 4.3 Coordination of Benefits. Provider shall be paid in accordance with Sponsors's coordination of benefits rules. Provider shall make all reasonable efforts to ascertain whether other coverages exist for Covered Persons to whom Provider renders Dental Services, and shall notify Premier or Sponsor of any such other coverages in accordance with the Premier Provider Manual.

Section 4.4 Payment in Full and Financial Responsibility. Provider shall accept as payment in full for Dental Services to Covered Persons such amounts as are paid by Sponsor pursuant to this Agreement. In no event shall Provider bill a Covered Person for the difference between Provider's Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect from the Covered Person Copayments, Deductibles or charges for services not covered under the Covered Person's Benefit Contract. For those Sponsors listed in the Provider Manual who also extend the Fee Maximums to services not covered under the Benefits Contract, Provider may collect from the Covered Person for those services not covered under the Benefit Contract, the lesser of
(1) the Provider's Customary Charge for such service or (2) the Fee Maximum amount.

In the event Premier determines that a Sponsor has failed to maintain its responsibility to pay for services, the services rendered thereafter shall be considered ineligible for reimbursement, and Provider may bill the Covered Person directly for those services. Premier shall notify Provider in writing upon determining that a Sponsor has failed to maintain financial responsibility.

SECTION 5
Relationship Between Parties

Section 5.1 Relationship Between Premier and Provider. The relationship between Premier and Provider is solely that of independent contractors, and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

SECTION 6
Hold Harmless, Indemnification and Liability Insurance

Section 6.1 Provider Hold Harmless and Indemnification. Provider shall defend, hold harmless and indemnify Premier and Sponsor against any and all claims, liabilities, damages, or judgments asserted against, imposed upon or incurred by Premier or Sponsor that arise out of the acts or omissions of Provider or Provider's employees, agents, or representatives in the discharge of his or her or their professional responsibilities to a Covered Person under this Agreement.

Section 6.2 Premier Hold Harmless and Indemnification. Premier shall defend, hold harmless and indemnify Provider against any and all claims, liabilities, damages, or judgments asserted against, imposed upon or incurred by Provider that arise out of the negligence of Premier in the discharge of its responsibilities to Covered Persons.

Section 6.3 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense medical malpractice or professional liability insurance for each Dental Group Provider in the amount of Two Hundred Thousand ($200,000.00) per occurrence and Six Hundred Thousand ($600,000.00) aggregate or those minimum levels required by state law, with a recognized carrier. Provider shall also assure that all health care professionals employed by or under contract with Provider to render Dental Services to Covered Persons procure and maintain such insurance, unless they are covered under Provider's insurance policies. Provider's and other health care professionals' medical malpractice or professional liability insurance shall be either occurrence or claims made with an extended period reporting option under such terms and conditions as may be reasonably required by Premier. Prior to or within 30 days following execution of this Agreement by Provider and at each policy renewal thereafter, Provider shall submit to Premier in writing evidence of insurance coverage. Provider shall notify Premier in writing, to the attention of the President, within 10 days of any changes in carriers, termination of, renewal of or any material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium.

SECTION 7
Laws, Regulations, Licenses and Hospital Privileges

Section 7.1 Laws, Regulations, Licenses and Hospital Privileges. Provider shall maintain, and shall assure that all health care professionals employed by or under contract with Provider to render Dental Services to Covered Persons maintain, all applicable federal, state and local licenses, certifications, and permits, without restriction, required to provide health care services as dental care providers and to maintain Provider's facilities in the state of _____ and shall comply with all applicable statutes and regulations.

Provider shall notify Premier in writing, to the attention of the President, within 10 days of any suspension, revocation, condition, limitation, qualification, voluntary relinquishment, termination or other restriction on an Dental Group Provider's licenses, certifications, and permits by any state in which the Dental Group Provider is authorized to provide health care services; and, if applicable, of any suspension, revocation, condition, limitation, qualification, voluntary relinquishment, termination or other restriction of an Dental Group Provider's clinical or staff privileges at any licensed hospital, nursing home, or other facility at which the Dental Group Provider has clinical or staff privileges during the term of this Agreement.

SECTION 8
Name, Symbols, and Service Marks

Section 8.1 Rights of Provider, Premier and Sponsor. During the term of this Agreement, Provider, Premier, and Sponsor shall have the right to designate and make public reference to Provider, by name, symbol, and service mark, as a Premier Provider. Provider, Premier, and Sponsor shall not otherwise use each other's name, symbol, or service mark without prior written approval.

SECTION 9
Books and Records

Section 9.1 Access to and Release of Books and Records. Premier and Sponsor, during regular business hours and upon reasonable notice and demand, shall have access to all information and records or copies of records, free of charge, related to Dental Services rendered by Provider under this Agreement or related to analysis of the efficiency of health care management techniques by Premier. Unless otherwise required by applicable statutes or regulations, Premier and Sponsor shall have such access during the term of this Agreement and for 3 years following its termination. Provider shall provide records or copies of records requested by Premier or Sponsor within 14 days from the date such request is made.

Section 9.2 Compliance with Statutes and Regulations. The federal, state, and local government and any of their authorized representatives shall have access to, and Premier and Sponsor are authorized to release, in accordance with applicable statutes and regulations, all information and records, or copies of such, within the possession of Premier or Sponsor or Provider, which are pertinent to and involve transactions related to this Agreement and access to which is necessary to comply with federal and state statutes and regulations applicable to Premier or Sponsor.

Section 9.3 Privacy of Records. Premier, Sponsor, and Provider shall maintain the confidentiality of all information regarding Covered Persons in accordance with any applicable statutes and regulations.

SECTION 10
Resolution of Disputes

Section 10.1 Resolution of Disputes. In the event a dispute between Premier or Sponsor and Provider arises out of or is related to this Agreement, the parties to the dispute shall meet and negotiate in good faith to attempt to resolve the dispute. In the event the dispute is not resolved within 30 days of the date one party sent written notice of the dispute to the other party, and if any party wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association. In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in Hennepin County, Minnesota. The arbitrators shall have no authority to award any punitive or exemplary damages, or to vary or ignore the terms of this Agreement, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain Premier procedures, such as a credentialing or quality assurance plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke its right to arbitration under this section.

SECTION 11
Term and Termination

Section 11.1 Term. The term of this Agreement shall commence on the Effective Date and it shall remain in effect until terminated.

Section 11.2 Termination. This Agreement may be terminated as follows:

(1) by either party, without cause, upon 60 days prior written notice to the other party.
(2) by either party, with cause, upon 45 days prior written notice to the other party.
(3) by Premier immediately due to Provider's loss or suspension of licensure or loss of liability insurance required under this Agreement.
(4) by Premier upon 30 days prior written notice to Provider in the event Provider has objected to an amendment proposed pursuant to Section 12.1.

"Cause" is defined as a material breach of this Agreement.

If Provider has been terminated through the Premier credentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to that process.

Section 11.3 Information to Covered Persons. Provider acknowledges the right of Premier to inform Covered Persons of Provider's termination and agrees to cooperate with Premier in deciding on the form of such notification.

Section 11.4 Continuation of Services After Termination. Upon request of Premier, Provider shall continue to provide Necessary and Appropriate Dental Services to Covered Persons who are receiving such services from Provider as of the date of termination of this Agreement. Premier or Sponsor shall pay Provider for such services at Provider's Customary Charges.

Section 11.5 Termination of Dental Group Provider. A Dental Group Provider's participation with Premier may be terminated as follows:

(1) by Premier, without cause, upon 60 days prior written notice to Dental Group and Dental Group Provider.
(2) by Premier, with cause, upon 30 days prior written notice to Dental Group and Dental Group Provider.
(3) by Premier immediately due to the Dental Group Provider's loss or suspension of licensure or loss of liability insurance required under this Agreement.
(4) by Dental Group Provider, with or without cause, upon 60 days prior written notice to Premier and Dental Group.

SECTION 12
Miscellaneous

Section 12.1 Amendment. Premier may propose to amend this Agreement by sending a copy of the proposed amendment to Provider at least 90 days prior to the effective date of the amendment. If Provider objects to the amendment, Provider may submit to Premier, within 15 days of receipt of the amendment, a written statement explaining the reasons for the objection. If such a statement of objection is not received, the amendment shall become effective. If a statement of objection is received and if Premier and Provider are unable to resolve Provider's objections within 15 days of Premier receiving the statement of objection, the amendment shall not become effective; however, Premier may terminate this Agreement pursuant to Section 11.2 (4).

Section 12.2 Assignment. Premier may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by, or under common control with Premier. Provider acknowledges that persons and entities under contract with Premier may perform certain administrative services under this Agreement. Premier may not otherwise assign any of its rights and responsibilities under this Agreement to any other party without the prior written consent of Provider, which consent shall not be unreasonably withheld. Provider may not assign any of its rights and responsibilities under this Agreement to any person or entity without the prior written consent of Premier, which consent shall not be unreasonably withheld.

Section 12.3 Entire Agreement. This Agreement constitutes the entire agreement between the parties in regard to its subject matter.

Section 12.4 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state of Minnesota.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

THE PREMIER DENTAL GROUP, INC.-Sun Life

By_____

Greg Meagher

President

Date_____

Mailing Address:
2323 Grand Blvd
Kansas City, MO 64108

_____
(provider or dental group name)

Signed_____

Print Name_____

Print Title_____

Date_____

Tax I.D. Number used on Claims:

Exhibit 1
DENTAL GROUP PROVIDER PARTICIPATION LIST

Dental Group Provider Name	Location