EMPLOYER APPLICATION FOR GROUP DENTAL INSURANCE

dental by design

A COMPLETE DENTAL INSURANCE PORTFOLIO FROM COMPANION LIFE.

Companion Life Insurance Company • PO Box 100102 • Columbia, South Carolina 29202-3102
1-800-753-0404 • FAX (803) 735-0736

Please Print or Type

EMPLOYER INFORMATION

1. Full legal name of applicant (As it should appear in policy) Telephone Number ( )

2. Applicant's Federal Tax ID Number

3. Address Street Post Office Box ZIP

City County State

4. Administrative Correspondence with the Applicant should be addressed to:
Name Title

5. Nature of Business

6. Requested Effective Date:

7. Are there subsidiary businesses covered under this plan? ☐ Yes ☐ No
If YES, please state name and nature of each subsidiary or affiliate.

Are separate billings required? ☐ Yes ☐ No
If YES, please provide billing instructions.

8. Type of Administration: ☐ Home Office Administered ☐ Self Administered

EMPLOYEE ELIGIBILITY

9. The normal work week for full-time employees must be at least 30 hours unless otherwise approved by Companion Life.

10. Current eligible employees are to be covered:
- ☐ Immediately on the requested effective date.
- ☐ After _____ days of continuous employment.
- ☐ First of the month following _____ days of continuous employment.

11. Employees hired after the plan effective dates are to be covered:
- ☐ Immediately.
- ☐ After _____ days of continuous employment.
- ☐ First of the month following _____ days of continuous employment.

12. Coverage following completion of the waiting period selected will be effective the first of the month following completion of the waiting period or the next billing date.

13. Number of Eligible Employees: __________

14. Number of Enrolled Employees: __________

SPECIFICATIONS FOR INSURANCE

15. Percent of Premium Paid by Employer: ☐ Single/Employee Only ☐ Family/Employee & Dependents _____%

16. Will this coverage replace any existing dental insurance plan? ☐ Yes ☐ No
If YES, name present insurance carrier:

17. Existing Plan Effective Date:

18. Termination Date of Existing Plan

19. Check coverages being replaced: ☐ Preventive ☐ Basic ☐ Major ☐ Orthodontia

20. Is prior insurance credit (takeover benefits) requested? ☐ Yes ☐ No

21. The following documentation is required when prior insurance credit is requested. Your current dental plan must have been in effect continuously for at least 12 months prior to effective date.
- Evidence that the prior carrier's coverage has been in force for at least 12 months.
- A copy of the most recent bill which includes a listing of all covered employees.
- A list of the covered employees with the prior carrier which includes the employee's effective dates of coverage.
- A copy of the inforce dental plan which may be a contract, certificate, or booklet.

Select Your *dental by design* Program On the Reverse

22. **Select Standard Benefit Design (REQUIRED)**	☐ **Dental Essentials**	☐ **Dental Choice**	☐ **Dental Select**
Program Deductible (all services)	$100 Lifetime	$100 Lifetime	$100 Lifetime
Type I – Preventive Services	**100%** oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)	**100%** oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants	**100%** oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants, full mouth X-rays
Type II – Basic Services (Waiting Period)	**80%** space maintainers, fillings, treatment, sealants, full mouth X-rays None	**80%** full mouth X-rays, fillings, simple extractions, endodontics None	**80%** fillings, anesthesia, simple & surgical extractions, endodontics, oral surgery, periodontics None
Type III – Major Services (Waiting Period)	**50%** anesthesia, endodontics, simple & surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants 12 months	**50%** anesthesia, surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants 12 months	**50%** crowns, inlays, onlays, dentures, bridges, implants 12 months
Contract Year Maximum	$1,000	$1,200	$1,500
Type IV – Orthodontia $1,000 Lifetime Orthodontial Maximum Deductible (Waiting Period)	**50%** ☐ Yes ☐ No None 12 months	**50%** ☐ Yes ☐ No None 12 months	**50%** ☐ Yes ☐ No None 12 months
Takeover Benefit	Preferred	Preferred	Preferred

23. ☐ **NO DESIGN OPTIONS – Issue Standard Benefit Design (above)**

– OR –

24. **Choose Design Options (if any) (below)**	**Dental Essentials**	**Dental Choice**	**Dental Select**
Incentive Plan – Percentage Increases in 2nd and 3rd years; No Waiting Periods Apply; Incentive Plan Takeover Only; If Selected, Child Orthodontia Max is $375 annually and $1,000 Lifetime	☐ Yes ☐ No 1st yr./2nd yr./3rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%	☐ Yes ☐ No 1st yr./2nd yr./3rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%	☐ Yes ☐ No 1st yr./2nd yr./3rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%
Contract Year Deductible Amount per Individual Limit Per Family Waive Deductible for Type I Services? (N/A for Lifetime Deductible)	☐ $25 ☐ $50 ☐ $100 ☐ 3 ☐ No Limit ☐ Yes ☐ No	☐ $25 ☐ $50 ☐ $75 ☐ $100 ☐ 2 ☐ 3 ☐ No Limit ☐ Yes ☐ No	☐ $25 ☐ $50 ☐ $75 ☐ $100 ☐ 2 ☐ 3 ☐ No Limit ☐ Yes ☐ No
Frequency of Cleanings / Exams	☐ 1 per 12 months	☐ 1 per 12 months	☐ 1 per 12 months
Frequency of Bitewing X-Rays	☐ 2 per 12 months	☐ 2 per 12 months	☐ 2 per 12 months
Change the **Contract Year Maximum**	☐ $500 ☐ $750 ☐ $1,200 ☐ $1,500 ☐ $2,000	☐ $500 ☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $500 ☐ $750 ☐ $1,000 ☐ $,1200 ☐ $2,000
Add **Retiree Dental Benefit**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Change the **Premium Rate Structure (Standard is Four Tiers)**	☐ Two Tiers ☐ Three Tiers	☐ Two Tiers ☐ Three Tiers	☐ Two Tiers ☐ Three Tiers

THE FOLLOWING DESIGN OPTIONS ARE NOT AVAILABLE WITH THE INCENTIVE PLAN:			
Change **Coinsurance**	☐ 100/50/50 ☐ 80/80/50	☐ 100/50/50 ☐ 80/80/50	☐ 100/50/50 ☐ 80/80/50
Add a **Type II Waiting Period** Six Month Wait for **Fillings Only**	☐ 6 months ☐ 12 months ☐ Yes	☐ 6 months ☐ 12 months ☐ Yes	☐ 6 months ☐ 12 months ☐ Yes
Change the **Type III Waiting Period**	☐ No Waiting Period ☐ 6 months ☐ 24 months	☐ No Waiting Period ☐ 6 months ☐ 24 months	☐ No Waiting Period ☐ 6 months ☐ 24 months
Increase the **Contract Maximum by $250 per Year** Maximum Cap after Increases $2,500/yr.	☐ Yes ☐ No ☐ 2 Increases ☐ 3 Increases	☐ Yes ☐ No ☐ 2 Increases ☐ 3 Increases	☐ Yes ☐ No ☐ 2 Increases ☐ 3 Increases
Change the **Orthodontia Option** Orthodontia Lifetime Max Orthodontia Waiting Period **Adult Orthodontia**	☐ $750 ☐ $1,500 ☐ $2,000 ☐ 24 months ☐ None ☐ Yes ☐ No	☐ $750 ☐ $1,500 ☐ $2,000 ☐ 24 months ☐ ☐ Yes ☐ No	☐ $750 ☐ $1,500 ☐ $2,000 ☐ 24 months ☐ None ☐ Yes ☐ No
Takeover Option	☐ Standard Takeover	☐ Standard Takeover	☐ Standard Takeover

EMPLOYER'S SIGNATURE

FRAUD WARNING (Not Applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Quotations were based on the proposal data submitted to Companion Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

Dated at ______________________ (City/State) this __________ day of ______________________, 20 __________

______________________ Signature of Employer ______________________ Title ______________________ Witness

AGENT'S REPORT

25. Initial Deposit (Minimum first month's premium is required.) $

26. Agent/Broker Name (Please Print) Telephone Number ( )

27. Address Post Office Box

City County State ZIP

28. Are there other group insurance plans which duplicate any of the benefits applied for with this application that will remain in force or be placed concurrently with this plan(s)?
☐ Yes ☐ No If YES, please describe the benefit amounts and purposes of these plans:

29. Is Agent or Broker licensed and appointed by Companion for the types of insurance solicited where this group is located?
☐ Yes ☐ No Agent Code Number ______________ State License______________

30. Signature of Agent/Broker ______________________________ Date ______________

www.CompanionLife.com

GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST

Companion Life Insurance Company

P.O. Box 100102 • Columbia, S.C. 29202
800-753-0404 (Phone) • 800-836-5433 (Fax)

☐ New Employee ☐ Add/Increase Coverage ☐ Change Beneficiary ☐ COBRA
☐ Change Address ☐ Change Dependent Coverage ☐ Change Class or Status ☐ Terminate Coverage

Companion Use Only
Approved: ☐ Declined: ☐
Date:______
By:______

TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application)	Group No. (10 digit #)	DEPT/DIV (3 digit #)	CLASS

TO BE COMPLETED BY EMPLOYEES

Social Security Number	Effective Date (Month / Day / Year)	Date Employed Full Time (Month / Day / Year)	Date of Birth (Month / Day / Year)	Hours Worked Per Week

Your Name Last First M.I. | Sex ☐ Female ☐ Male | ☐ Weekly ☐ Monthly ☐ Annually (Do not include overtime or bonuses.) Earnings $______

Marital Status ☐ Single ☐ Married | Occupation | Your Home Address | City | State | Zip Code

COMPLETE FOR LIFE AND/OR DISABILITY

COVERAGE REQUESTED ☐ Basic Life Insurance ☐ AD&D ☐ Dependent Life Insurance ☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary LTD

☐ Voluntary Life (Amount Selected) EMPLOYEE: Life $ AD&D $ SPOUSE: Life $ AD&D $ CHILD: Life $

Spouse Name: (Voluntary Life Only) Last First Middle | Birthdate | Social Security Number

Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage.)*
Last First Middle Relationship to Insured

COMPLETE FOR DENTAL AND/OR VISION

Coverage Requested: ☐ Dental For Employee Only ☐ Vision For Employee Only ☐ Dental For Employee and Dependents ☐ Vision For Employee and Dependents

Is your spouse to be covered? ☐ **Yes** ☐ **No**

Dental and/or Vision Coverage Is For (Check Box Below): ☐ Employee ☐ Employee plus Spouse ☐ Employee plus Child(ren) ☐ Family

Are you or any of your dependents covered for dental insurance under another policy? ☐ Yes ☐ No

Complete for Dependent Coverage Spouse Name (Last) (First) (Middle Initial)	**Full-time Student Y/N**	**Date of Birth**	**Gender M or F**	**Do any of your dependents have any other dental coverage?**	**If Yes, Name of Carrier**
		/ /		☐ Yes ☐ No	
CHILDREN 1		/ /		☐ Yes ☐ No	
2		/ /		☐ Yes ☐ No	
3		/ /		☐ Yes ☐ No	
4		/ /		☐ Yes ☐ No	

REFUSAL OF GROUP INSURANCE

I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Coverage Refused (Check All That Apply): ☐ Basic Life ☐ AD&D ☐ Dependent Life ☐ Voluntary Life ☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary LTD ☐ Dental ☐ Voluntary Dental

FRAUD WARNING (Not Applicable in AZ, FL, GA, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Your Signature X

NOTICE TO PROPOSED INSURED – DETACH AND GIVE TO PROPOSED INSURED

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.