



EMPLOYER APPLICATION FOR GROUP DENTAL INSURANCE

dental by design

Companion Life Insurance Company • PO Box 100102 • Columbia, South Carolina 29202-3102

FAX (803) 735-0736
1-800-753-0404

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 Zip
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? If YES, please state name and nature of each subsidiary or affiliate.
Are separate billings required? 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 is: ___ hours. The normal work week for full-time employees must be at least 30 hours.
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 ___% (25% required) Family/Employee & Dependents ___%
16. Will this coverage replace any existing dental insurance plan? 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.

22. Select Standard Benefit Design (REQUIRED)	<input type="checkbox"/> Dental Essentials	<input type="checkbox"/> Dental Choice	<input type="checkbox"/> Dental Select
Program Deductible (all services)	\$125 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 treatments, sealants, full mouth x-rays
Type II – Basic Services (No Benefit Waiting Period)	80% space maintainers, fillings, pain treatment, sealants, full mouth x-rays	80% full mouth x-rays, fillings simple extractions, endodontics	80% fillings, anesthesia, simple & surgical extractions, endodontics, oral surgery, periodontics
Type III – Major Services (12 Month Benefit 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
Is Orthodontia Coverage Requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

23. NO DESIGN OPTIONS – Issue Standard Benefit Design (above) | SELECT DESIGN OPTIONS BELOW ONLY IF NOT REQUESTING STANDARD BENEFIT DESIGN.

24. Select Design Options (if any)	Dental Essentials	Dental Choice	Dental Select
Change Coinsurance	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50
Deductible Options			
Change Lifetime Deductible	<input type="checkbox"/> \$100	N/A	N/A
Contract Year Deductible Amount per Individual Limit Per Family	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit	<input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit	<input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit
Waive Deductible for Type I Services? (N/A for Lifetime Deductible)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequency of Cleanings / Exams / X-Rays	<input type="checkbox"/> 2 per 12 months	<input type="checkbox"/> 1 per 12 months	<input type="checkbox"/> 1 per 12 months
Add a Type II Waiting Period Six Month Wait for Fillings only	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes
Change the Type III Waiting Period	<input type="checkbox"/> 24 months	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months
Change the Contract Year Maximum	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1200	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$1200 <input type="checkbox"/> \$2000
Change the Orthodontia Option Orthodontia Lifetime Max Orthodontia Waiting Period	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> 24 months	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> 24 months	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> 24 months
Enhanced Takeover Option (Groups 25+ only) Groups of 25-99 require 75% employee participation	N/A	<input type="checkbox"/> Enhanced Takeover	<input type="checkbox"/> Enhanced Takeover
Change the Premium Rate Structure (Standard is Three Tiers)	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Four Tiers	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Four Tiers	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Four Tiers

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.

If the initial deposit is at least equal to the first month's premium, and if the requested insurance is acceptable under Companion Life's current rules and practices, insurance under the terms of the policy shall be effective on the effective date requested. Otherwise, insurance will become effective only when a policy is delivered and accepted in writing; in the interim, liability is limited to a return of the original deposit. Only Companion Life's Home Office has the authority to guarantee the acceptability of the requested insurance.

Dated at _____ this _____ day of _____, 20 _____
City/State

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 _____ City _____ County _____ State _____ Zip _____ Post Office Box _____	
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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Agent Code Number _____ State License _____	
30. Signature of Agent/Broker _____ Date _____	