FORT DEARBORN LIFE INSURANCE COMPANY
Chicago, IL

APPLICATION & CHANGE FORM
GROUP VOLUNTARY DENTAL BENEFITS

I. APPLICANT
☐ New Application ☐ Change*

* To change your voluntary dental program, complete the items marked with a ✓ in Part I, check coverage in Part II, and sign in Part III.

✓ Employer Name

✓ Contact (Name/Title)

Mailing Address (DO NOT USE P.O. BOX)	Street	City	State	ZIP Code

✓ Phone:(___)_____ Fax:(___)_____ ✓ Email:	Nature of Business	SIC Code

✓Effective Date	First Anniversary	Number Of Eligible Employees	Number Enrolled	✓ Group Number

Waiting Period:
☐ None ☐ _____Days ☐ First of month following _____Days
Applicable to: ☐ All Employees ☐ Future Employees Only

Effective Date of Employee Participation:
The effective date of dental coverage is the first (1st) of the month following or coincidental to completion of any waiting period.

Does this coverage replace existing dental coverage? ☐ Yes ☐ No
Continuity of coverage for transfer insureds at takeover rates? ☐ Yes (PROVIDE COPY OF PRIOR PLAN &LAST LIST BILL) ☐ No

II. SCHEDULE OF BENEFITS (Select one Plan and the Plan shall be available to all eligible employees)

☐ **SCHEDULED BENEFIT PLAN** (Minimum Enrollment 2 Eligible Employees)
Plan pays a scheduled amount to service provider based on coverage level, procedure and region.

Coverage Level (select one)
☐ Gold (with orthodontics) ☐ Silver (without orthodontics) ☐ Bronze (without orthodontics)
☐ Gold and Bronze ☐ Silver and Bronze

Region ☐ Region 1 ☐ Region 2 ☐ Region 3 ☐ Region 4 ☐ Region 5

☐ **REASONABLE & CUSTOMARY (R&C) BENEFIT PLAN** (Minimum Enrollment 30 Eligible Employees)
R&C plan pays a percentage of the reasonable and customary charges to the service provider based on coverage level and procedure. The additional Bronze Plan is not R&C and does not include orthodontic coverage. Bronze Plan pays a *scheduled* amount to the service provider based on procedure and region.

Coverage Level (select one)
☐ Gold R&C (with orthodontics) ☐ Gold R&C and Bronze Scheduled Plan*
☐ Silver R&C (without orthodontics) ☐ Silver R&C and Bronze Scheduled Plan*

***Region** (required only if a Bronze Plan is elected) ☐ Region 1 ☐ Region 2 ☐ Region 3 ☐ Region 4 ☐ Region 5

III. GENERAL CONDITIONS It is understood and agreed that:

1. This application shall be made part of the Policy for which application is made.
2. All active employees who work at least_____hours a week are eligible (minimum 20 hours; 17 1/2 hours in VT).
3. Employee coverage is subject to the following conditions: Each employee must make written application to Fort Dearborn Life and sign an authorization for payroll deduction. Employees must be Actively At Work on their effective date of coverage, or coverage will be deferred until the date they return to Active Work. If an employee does not return to Active Work, he will not be covered.
4. Premiums are due and payable monthly on the first day of each month.
5. Except in LA, MD, ME, OR, SD, VT & WA, coverage is provided under a master group policy issued to DNoA Dental Plan Trust II.

The undersigned has read this entire application for dental insurance and agrees: (a) the information provided is accurate to the best of my knowledge; (b) this application and any other information I provide shall serve as the basis for the insurance to be issued; (c) I have a duty to notify the Company of any changes; and (d) I have relied on no oral or written representations that contradict item (3) above.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or statement of claim containing any materially false information and conceals information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties. (Not enforceable in OR, VA or VT)
New Jersey Applicants Only: Any person who knowingly files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

Signed at _____, this _____ day of _____ Year:_____

_____ Authorized Signature

_____ Licensed Resident Agent (If required)

STATEMENT OF UNDERSTANDING

between

FORT DEARBORN LIFE INSURANCE COMPANY (FDL)

and

_____ ("the Employer")

The Employer hereby grants FDL the right to offer each of the Employer's eligible employees, as defined in the application, the opportunity to participate in the Voluntary Benefit Program. This authorization is based on the following reciprocal agreements:

1. An enrollment will be conducted of the Employer's eligible employees. An initial enrollment period will be held from _____ through _____. Annual enrollments will be held _____.
2. The Employer agrees to provide a letter endorsing the Voluntary Benefit Program.
3. The Employer agrees to distribute FDL enrollment materials to all eligible employees.
4. The Employer agrees to collect and communicate to FDL acceptance or declination of the plan by each eligible employee.
5. The Employer will administer payroll deductions for the employees and remit premiums monthly on the first of each month.
6. The Employer agrees to notify FDL as soon as possible when the voluntary or involuntary termination of a participating employee takes place.

Signed this _____day of_____,Year_____

_____

Authorized Signature / Employer

_____

Authorized Signature / FDL

THE LAWS OF SOME STATES REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE:

Arkansas
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kansas
Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties.

New Jersey
Any person who knowingly files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

New Mexico
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Oklahoma
Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Washington
Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.