COMPANION LIFE INSURANCE COMPANY

P. O. Box 100102 Columbia, SC 29202

Application for Group Dental Coverage

Application is made to Companion Life Insurance Company for a Dental Policy, the provisions of which shall be made available to all eligible classes of Employees.

GENERAL INFORMATION

1. APPLICATION FOR
   a. Type of coverage: ☐ Dental Cents-A ☐ Dental Cents-B ☐ Premier ☐ Premier-MAC ☐ Advantage ☐ Advantage-MAC

   b. Requested effective date: _____
   (Mo.) (Day) (Year)
2. EMPLOYER
   a. Full legal name: _____
   b. ☐ Corporation ☐ Proprietorship ☐ Partnership
   c. HR Contact: _____ Accts Payable Contact: _____
   d. Employer Identification Number (EIN): _____
   e. Primary business address in state policy is issued:
   _____
   (Street) (City) (State) (Zip)
   f. Billing address (if different than above):
   _____
   (Street) (City) (State) (Zip)
   g. Telephone Number: ( ) _____ Ext. _____
   Fax Number: ( ) _____ E-mail: _____
   h. Nature of Business: _____ **SIC Code:** _____
   i. Affiliates or subsidiaries to be covered (use "Additional Information on page 4 for this if more space is needed):

_____ (Full Legal Name)	_____ (Full Legal Name)
_____ (Street Address)	_____ (Street Address)
_____ (City, State, Zip)	_____ (City, State, Zip)
_____ (Nature of Business)	_____ (Nature of Business)

   j. Number of eligible employees residing outside of the state in which the policy was issued:

_____ (State and number of employees)	_____ (State and number of employees)

3. OTHER COVERAGE INFORMATION
   a. Will this coverage supplement other Dental coverage? ☐ Yes ☐ No
   If yes, what other coverage will be provided? _____
   b. Will alternative coverage through a DHMO or other capitation plan be offered? ☐ Yes ☐ No
   If yes, show name of capitation plan. _____
   c. Will this coverage replace a current program? ☐ Yes ☐ No
   If yes, who is the current carrier? _____

Return to: Total Dental Administrators, Inc.
2111 East Highland Avenue, Suite 250, Phoenix, AZ 85016
(602) 266-1995

ELIGIBILITY

1. CLASSES OF ELIGIBLE EMPLOYEES
   a. Active employees
   - All active full-time employees (A full-time employee must work 30 hours per week of compensable time.)
   - Specific class or classes only (Specify class, such as hourly, salaried, covered or not covered by collective bargaining, etc.:_____
     _____
     _____

   b. Other - Explain if there are any persons who will be enrolled who are not actively employed: i.e., retirees, COBRA, etc.: _____

2. NUMBER OF ELIGIBLE EMPLOYEES IN ELIGIBLE CLASSES

a. Total number of employees on the payroll			_____
b. Less number of employees not eligible			
1) Temporary or seasonal employees	(_____)		
2) Employees working less than 30 hours per week	(_____)		
3) Employees serving probationary period	(_____)		
4) Employees enrolled in a DMO or Capitation plan	(_____)		
5) Total ineligible employees			(_____)
c. Net eligible employees (a minus b.5)			(_____)
d. Number of eligible employees who will not be enrolled. Specify Reason: _____			(_____)
e. Number of eligible employees who will be enrolled. (c minus d)			_____

3. DEPENDENT ELIGIBILITY

   Spouse and/or unmarried children to age 19 or to age 24 if unmarried and a full time student in an accredited school. If there are any additional eligibility requirements for dependents, please specify:
   _____

4. ENROLLMENT
   To enroll, timely application must be made to Companion Life Insurance Company. Eligible employees must submit a completed application card to the Employer within 30 days following completion of a _____(0, 30, 60, 90, etc.) day probationary period. Coverage will be effective first of the month following the probationary period.

   NOTE: ELIGIBLE employees or their dependents that do not enroll when they first become eligible will be considered a "Late Entrant" or must wait until the next open enrollment period, unless Retroactive Coverage is an eligible option and has been selected herein by the Employer.

EMPLOYERS CONRIBUTIONS

1. PERCENT OR AMOUNT
   The Employer agrees to make the following contribution toward the cost of the employee and dependent coverage:

   Employee _____ %
   Dependent _____ %

TERM OF CONTRACT

1. TERM OF CONTRACT ☐ One Year ☐ Other (Specify) _____

PREMIUMS AGREED TO

1. **2 - Tier** ☐ **3 - Tier** ☐ **4 - Tier** ☐

2 - Tier	3 - Tier	4 - Tier	
Employee	Employee	Employee	_____ per month
Employee & Family	Employee & 1 Dep.	Employee & Spouse	_____ per month
	Employee & Family	Employee & Child(ren)	_____ per month
		Family	_____ per month
		Ortho Rider ☐ Yes ☐ No	_____ per month

2. Initial amount submitted with this Application $ _____
Please attach a copy of the initial Census.

SIGNATURES

FRAUD WARINING: 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 there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

1. AGREEMENT

a. This application is signed by a person or persons authorized by the Employer to make such an agreement; and
b. The application is received and approved by the Companion Life Insurance Company at its home office; and
c. The initial month's premium is received by Companion Life Insurance Company.

Coverage is effective on the first billing due date after the conditions in (a), (b), and (c) above have been met. Coverage is subject to all the terms and conditions of the Group Dental Policy.

2. SIGNATURES

For a corporation, the President or Vice President and the Secretary or Acting Secretary should sign. For a proprietorship, the owner should sign. For a partnership, any partner should sign.

I have read this application, agreed to the terms, and certify that all statements are true and complete. It is understood that provisions of the Group Dental Policy, including premiums therefore, may be amended or changed from time to time, upon written notice from Companion Life Insurance Company to the Employer.

By _____
(print name)

_____
(sign name)

Title _____

Date _____

Witnessed by:

_____ _____
(print agent's name) License No.

By_____
(sign agent's name)

Date _____