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: ☐ PPO
   b. Requested effective date: ____
   (Mo.) (Day) (Year)
2. EMPLOYER
   a. Full legal name: ____
   b. ☐ Corporation ☐ Proprietorship ☐ Partnership
   c. H.R. Person: ______________________________ 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 #B-425 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 23 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 who 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 ______________________ %

PLAN DESCRIPTION - PPO

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

2. PLAN OPTIONS (Select Applicable Plan): ☐ Plan A - Endodontics and Periodontal Services as Class II Benefits
   ☐ Plan B - Endodontics and Periodontal Services as Class III Benefits

   DEDUCTIBLE (Based Upon Proposed Plan):

   Per person: ☐ $25 ☐ $50 ☐ $100 ☐ $200 Waived for Class I ☐Yes ☐ No
   Per Family ☐ $75 ☐ $150 ☐ $300 ☐ $600

MAXIMUM BENEFIT PER YEAR (Based Upon Proposed Plan):

Per Person ☐ $750 ☐ $1,000 ☐ $1,200 ☐ $1,500 ☐ $2,000
Per Calendar Year for all Covered Dental Benefits - (Class I, II, and Class III)

THE POLICY WILL PAY - "OUT-OF-NETWORK" (Based Upon Proposed Plan):

PPO -	Class I:	Preventative	☐ 50%	☐ 60%	☐ 70%	☐ 80%	☐ 90%	☐ 100%	of the Allowable Fee*
	Class II:	Basic	☐ 50%	☐ 60%	☐ 70%	☐ 80%	☐ 90%	☐ 100%	of the Allowable Fee*
	Class III:	Major	☐ 40%	☐ 50%	☐ 60%	☐ 70%	☐ 80%		of the Allowable Fee*

Twelve (12) Month Class III Waiting Period Waived (Based Upon Proposed Plan)? ☐ Yes ☐ No
Credit requested for time covered under this employer's prior Plan (plan being replaced)? ☐ Yes ☐ No
If a Takeover of Benefits Credit is to be considered for Class III and Class IV, the following must be provided:

a. Name of Prior Carrier____
b. Effective Date of Prior Plan:_____________ c. Termination Date of Prior Plan:_________

The employer must also submit a copy of (1) the prior carrier's most recent billing statement; (2) a certificate or letter of acceptance that shows the effective date of the prior plan; and (3) the prior carrier's certificate, booklet or schedule of benefits.

Class IV: Ortho** (Based Upon Proposed Plan) ☐ Yes ☐ No ☐ 50% ☐ 60% of the Allowable fee
for Children only to age 19.
Adult and Child Ortho (subject to special underwriting requirements & approval) ☐ Yes ☐ No

Twelve (12) Month Class IV Waiting Period Waived (Based Upon Proposed Plan)? ☐ Yes ☐ No

Credit requested for time covered under this employer's prior Plan (plan being replaced)? ☐ Yes ☐ No
(If yes, complete the above information for Takeover of Benefits Credit)

** The Orthodontic Lifetime Maximum (if applicable is): ☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000

PPO Payment "In Network" (Based Upon Proposed Plan) - Class I______% Class II______% Class III______%

PREMIUMS AGREED TO

1. **PPO:**

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

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

SIGNATURE

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 ________________________