

**EMPLOYER APPLICATION FOR
GROUP DENTAL INSURANCE**





Dental by Design Program

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

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

9. 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.
10. 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.
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.
11. Number of Eligible Employees: 12. Number of Enrolled Employees:

SPECIFICATIONS FOR INSURANCE

13. Percent of Premium Paid by Employer: Employee Only % Family/Employee & Dependents %
14. Will this coverage replace any existing dental insurance plan? If YES, name existing insurance carrier:
15. Existing Plan Effective Date: 16. Termination Date of Existing Plan 17. Check coverages being replaced: Preventive Basic Major Orthodontia
18. Is prior insurance credit (takeover benefits) requested? Yes No
19. 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.
20. For Groups with less than 50 employees; are the Pediatric Oral EHB benefits imbedded in your medical plan? Yes No
21. SELECT PLAN: Traditional Plan - Traditional Benefits for Employee, Spouse and Children to age 26
Adult Dental Plan - Traditional Benefits for Employee, Spouse and Children ages 19 to 26 (No coverage for Children under 19; Child Orthodontia is not available for this plan)
Adult Plus Child Wrap Dental Plan - Traditional Benefits for Employee, Spouse and Children ages 19 to 26; Wrap Benefits for Children under 19.
Adult Plus Pediatric EHB Dental Plan- Traditional Benefits for Employee, Spouse and Children ages 19-26; Certified Pediatric EHB Benefits for Children under age 19.

COMPANION LIFE

22. SELECT BENEFIT DESIGN	<input type="checkbox"/> Standard Dental Essentials	<input type="checkbox"/> Standard Dental Choice	<input type="checkbox"/> Standard 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, pain 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	\$1,000	\$1,000
Type IV – Orthodontia \$1,000 Lifetime Orthodontial Maximum Deductible (Waiting Period)	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months
Takeover Benefit	Preferred	Preferred	Preferred

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

24. THE FOLLOWING DESIGN OPTIONS ARE NOT AVAILABLE WITH THE INCENTIVE PLAN:			
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
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"/> 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	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months
Increase the Contract Maximum by \$250 per Year Maximum Cap after Increases \$2,500/yr.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases
Change the Orthodontia Option Orthodontia Lifetime Max Orthodontia Waiting Period Adult Orthodontia	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No
Takeover Option	<input type="checkbox"/> Standard Takeover	<input type="checkbox"/> Standard Takeover	<input type="checkbox"/> 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 _____ 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 _____

28. Agent/Broker Email Address: _____

29. 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:

30. 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 _____

31. Signature of Agent/Broker _____ Date _____



www.CompanionLife.com

PRODUCTS NOT APPROVED IN ALL STATES