EMPLOYER APPLICATION FOR GROUP DENTAL INSURANCE

dental by design®

A COMPLETE DENTAL INSURANCE PORTFOLIO FROM COMPANION LIFE.

Companion Life®

Companion Life Insurance Company • PO Box 100102 • Columbia, South Carolina 29202-3102
800-753-0404 • FAX 803-735-0736

dental by design®

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.
   ☐ Yes ☐ No

   Are separate billings required? If YES, please provide billing instructions.
   ☐ Yes ☐ No

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:
   ☐ Yes ☐ No

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.
   - 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 and their effective dates of coverage (Standard Takeover only).
   - A copy of the inforce dental plan which may be a contract, certificate, or booklet.

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	☐ Standard Dental Essentials	☐ Standard Dental Choice	☐ 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%** ☐ Yes ☐ No None 12 months	**50%** ☐ Yes ☐ No None 12 months	**50%** ☐ Yes ☐ 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)	☐ $25 ☐ $50 ☐ $100 ☐ 3 ☐ No Limit ☐ Yes ☐ No	☐ $25 ☐ $50 ☐ $75 ☐ $100 ☐ 2 ☐ 3 ☐ No Limit ☐ Yes ☐ No	☐ $25 ☐ $50 ☐ $75 ☐ $100 ☐ 2 ☐ 3 ☐ No Limit ☐ Yes ☐ No
Frequency of Cleanings / Exams	☐ 1 per 12 months	☐ 1 per 12 months	☐ 1 per 12 months
Frequency of Bitewing X-Rays	☐ 2 per 12 months	☐ 2 per 12 months	☐ 2 per 12 months
Change the **Contract Year Maximum**	☐ $500 ☐ $750 ☐ $1,200 ☐ $1,500 ☐ $2,000	☐ $500 ☐ $750 ☐ $1,200 ☐ $1,500 ☐ $2,000	☐ $500 ☐ $750 ☐ $1,200 ☐ $1,500 ☐ $2,000
Add **Retiree Dental Benefit**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Change the **Premium Rate Structure** **(Standard is Four Tiers)**	☐ Two Tiers ☐ Three Tiers	☐ Two Tiers ☐ Three Tiers	☐ Two Tiers ☐ Three Tiers
Incentive Plan – Percentage Increases in 2nd and 3rd years; No Waiting Periods Apply; Incentive Plan Takeover Only; If Selected, Child Orthodontia Max is $375 annually and $1,000 Lifetime	☐ Yes ☐ No 1st yr./2nd yr./3rd yr. Type I–80%/100%/100% Type II–50%/65%/80% Type III–25%/35%/50% Type IV–25%/35%/50%	☐ Yes ☐ No 1st yr./2nd yr./3rd yr. Type I–80%/100%/100% Type II–50%/65%/80% Type III–25%/35%/50% Type IV–25%/35%/50%	☐ Yes ☐ No 1st yr./2nd yr./3rd 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**	☐ 100/50/50 ☐ 80/80/50	☐ 100/50/50 ☐ 80/80/50	☐ 100/50/50 ☐ 80/80/50
Add a **Type II Waiting Period** Six Month Wait for **Fillings Only**	☐ 6 months ☐ 12 months ☐ Yes	☐ 6 months ☐ 12 months ☐ Yes	☐ 6 months ☐ 12 months ☐ Yes
Change the **Type III Waiting Period**	☐ No Waiting Period ☐ 6 months ☐ 24 months	☐ No Waiting Period ☐ 6 months ☐ 24 months	☐ No Waiting Period ☐ 6 months ☐ 24 months
Increase the **Contract Maximum by $250 per Year** Maximum Cap after Increases $2,500/yr.	☐ Yes ☐ No ☐ 2 Increases ☐ 3 Increases	☐ Yes ☐ No ☐ 2 Increases ☐ 3 Increases	☐ Yes ☐ No ☐ 2 Increases ☐ 3 Increases
Change the **Orthodontia Option** Orthodontia Lifetime Max Orthodontia Waiting Period **Adult Orthodontia**	☐ $750 ☐ $1,500 ☐ $2,000 ☐ 24 months ☐ None ☐ Yes ☐ No	☐ $750 ☐ $1,500 ☐ $2,000 ☐ 24 months ☐ ☐ Yes ☐ No	☐ $750 ☐ $1,500 ☐ $2,000 ☐ 24 months ☐ None ☐ Yes ☐ No
Takeover Option	☐ Standard Takeover	☐ Standard Takeover	☐ 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 _____

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PRODUCTS NOT APPROVED IN ALL STATES