EMPLOYER APPLICATION FOR GROUP DENTAL INSURANCE

Preferred United Plans®
"Dental Care"

Companion Life

Underwritten by: Companion Life Insurance Company

Administered by: SecureOne Benefit Administrators
678 Front Ave NW, Suite 420
Grand Rapids, MI 49504

SECUREONE™
Benefit Administrators, Inc.

Preferred United Plans®
"Dental Care"

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)

22. SELECT BENEFIT DESIGN	D-1	D-2	D-3	D-4
Program Deductible Per Individual Family Limit Waived for Type I service	$100 Lifetime No Limit No	$100 Lifetime No Limit No	$50 Contract Year 3 (Max $150) Yes	$100 Lifetime No Limit
Type I Preventive Services	100% Oral Exams, Cleanings (2 per 12 months) Bitewing X-Rays (1 per 12 months) Space Maintainers Pain Treatment, Sealants, Full Mouth X-Rays	100% Oral Exams, Cleanings (2 per 12 months) Bitewing X-Rays (1 per 12 months) Space Maintainers Pain Treatment, Sealants	80% Oral exams, Cleanings (2 per 12 months) Bitewing X-Rays (1 per 12 months) Space Maintainers Pain Treatment, Sealants, Full Mouth X-Rays	80% Oral exams, Cleanings (2 per 12 months) Bitewing X-Rays (1 per 12 months)
Type II Basic Services Benefit Waiting Period	80% Fillings, Anesthesia, Simple & Surgical Extractions, Endontics, Oral Surgery, Periodontics None	80% Full Mouth X-Rays, Fillings, Simple Extractions, Endontics None	80% Fillings, Anesthesia, Simple & Surgical Extractions, Endodontics, Oral Surgery, Periodontics None	80% Space Maintainers, Fillings, Pain Treatment, Sealants, Full Mouth X-Rays None
Type III Major Services Benefit Waiting Period	50% Crowns, Inlays, Onlays, Dentures, Bridges, Implants, Perio Trays 12 months	50% Anesthesia, Surgical Extractions Oral Surgery, Periodontics, Crowns, Inlays, Onlays, Dentures, Bridges, Implants, Perio Trays 12 months	50% Crowns, Inlays, Onlays, Dentures, Bridges, Implants, Perio Trays 12 months	50% Anesthesia, Endontics, Simple & Surgical Extractions, Oral Surgery, Periodontics, Crowns, Inlays, Onlays, Dentures, Bridges, Implants, Perio Trays 12 months
Contract Year Maximum Increasing Maximum	$1,000	$1,000	$1,000/ 0 Incr Max	$1,000
Type IV Orthodontia **Child(ren) Only** Lifetime Maximum Deductible Benefit Waiting Period	50% Child(ren) Only $1,000 None 12 Months	50% Child(ren) Only $1,000 None 12 Months	50% Child(ren) Only $1,000 None 12 Months	50% Child(ren) Only $1,000 None 12 Months
Takeover Benefit	Preferred	Preferred	Preferred	Preferred

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 _____ (City/State) this _____ day of _____, 20 _____

_____ 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 _____

Companion Life®

www.CompanionLife.com

PRODUCTS NOT APPROVED IN ALL STATES