GROUP DENTAL POLICY APPLICATION

Underwritten by: Companion Life Insurance Company
P.O. Box 100102
Columbia, South Carolina 29202
(803) 735-1251

Administered by: Companion Life Insurance Company
800 Main Street
P.O. Box 1535
Dubuque, IA 52004-1535
Telephone Number: (877) 676-5789
Fax: (563) 577-3351

NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

If More Space Is Needed, Please Attach A Separate Sheet, Signed And Dated By The Employer.

Please Print or Type

POLICYHOLDER INFORMATION

1. Full Legal Name of Employer (As it should appear in Policy) Telephone Number

2. Employer's Federal Tax ID Number Full Years in Business

3. Street Address City State ZIP

P.O. Box City State ZIP

4. Administrative Correspondence with the Employer should be addressed to:
Name Title Email Address

5. Nature of Business

6. Requested Effective Date:

7. Are there subsidiary or affiliate businesses covered under this plan? ☐ Yes ☐ No
If YES, please state name and nature of each subsidiary or affiliate.

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

8. Type of Administration: ☐ Home-Office Administered ☐ Self-Administered ☐ Third Party Administered

TPA Name ___________________________

ELIGIBILITY INFORMATION

9. An Eligible Active Employee is Full Time and works ________ hours or more per week and is a legal resident or citizen of the U.S.

BILLING INSTRUCTIONS

10. Frequency: ☐ Monthly
Billing Method: ☐ Electronic - Date of 1st Deduction ____
Amount submitted with Application $

11. Billing Agent's Name

12. Billing Address – Street Address, City, State, Zip Code (If different from the address above)

13. Employer's authorized Representative Printed Name

14. Employer's authorized Representative Signature Date

COVERAGE INFORMATION
SEE ATTACHED PROPOSAL FOR SPECIFICATIONS FOR INSURANCE

15. Will the requested insurance replace existing insurance? ☐ Yes ☐ No
If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date:

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

If YES, check coverages being replaced: ☐ Preventive ☐ Basic ☐ Major ☐ Orthodontia

16. Current eligible enrollees are to be covered:
☐ Immediately on the requested effective date.
☐ After ______ days of continuous employment
☐ 1st of the month following _____ days of continuous employment

17. Employees after the plan effective dates are to be covered:
☐ Immediately on the date of hire.
☐ After ______ days of continuous employment.
☐ 1st of the month following _____ days of continuous employment

18. Are any Employees excluded from coverage? ☐ Yes ☐ No
If YES, please describe

19. Number of eligible Employees:
Number of enrolled Employees:

20. Percent of Premium Paid by Employer Enrollee Only ______ % Dependents ______ %
Total Employer Defined Contribution: Enrollee Only $ ______ Dependents $ ______
Additional notes:

21. Is prior insurance credit (takeover benefits) requested? ☐ Yes ☐ No

22. The following documentation is required when prior insurance credit is requested. Your prior 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 enrollees.
- A copy of the prior dental plan.

23. SPECIAL REQUESTS/INSTRUCTIONS

EMPLOYER'S SIGNATURE

DO NOT CANCEL OTHER COVERAGE UNTIL NOTIFIED IN WRITING BY THE INSURANCE COMPANY OF ACCEPTANCE OF THIS APPLICATION

The undersigned, who is an officer of Employer and authorized to enter into this contract, certifies the following to be true:

1) all answers contained herein are true and complete;
2) the Company may institute inspection reports with regard to questions answered herein;
3) the Company may decline acceptance of the Application or where permitted by law, any person for whom coverage is requested;
4) no coverage will become effective under this plan of insurance until written approval is received from the Company; and
5) that the Company may terminate the policy(ies) by giving advance written notice as required in the Policy.

FRAUD NOTICE

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

PLEASE READ CAREFULLY

The Policy forms will be delivered to the group electronically unless you request in writing to receive a paper copy. The Certificate package for distribution to all insureds will be delivered to you electronically unless you request in writing to receive a paper copy for distribution.

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.
If the initial deposit is at least equal to the first month's premium, and if the requested insurance is acceptable under Companion Life's current rules and practices, insurance under the terms of the policy shall be effective on the effective date requested. Otherwise, insurance becomes effective only when a policy is delivered and accepted in writing. In the interim, liability is limited to a return of the original deposit, if any Only Companion Life's home office has the authority to guarantee the acceptability of the requested insurance.

Dated at ____________________________________ this__________________ day of______________________, 20_________________
City/State

____ _____________________________
Signature of Employer Title

AGENT/BROKER'S REPORT

24. INITIAL DEPOSIT $________________

25. Have you explained to the Employer that an Employee not actively at work on the policy effective date will not be covered until such Employee returns to active work full time unless approved in writing by an underwriter or officer of Companion Life?
☐ Yes ☐ No

Remarks

26. Is there another group insurance plan(s) which duplicates 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 purpose(s) of this plan(s).

27. Is Agent or Broker licensed in the state of this group for the types of insurance solicited? ☐ Yes ☐ No

28. To the best of the Agent's or Broker's knowledge, replacement
☐ is involved with this transaction.
☐ is not involved with this transaction.

29. Agent/Broker Name (Please Print)____

Agent/Broker Telephone Number_____________________________________

Agent/Broker Email Address ____

30 Signature of Agent/Broker ____Date ___________________________

www.CompanionLife.com

PRODUCTS NOT APPROVED IN ALL STATES