Companion Life

P.O. Box 100102, Columbia, SC 29202-3102

DENTAL EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

EMPLOYER (APPLICANT) INFORMATION (Please Print or Type)

Legal Name of Employer: ______________________________

Type of Business (Sole Proprietorship, Partnership, Corporation, etc.): ______________________________

Address: ______________________________ City: ______________ State: ______ ZIP: ______

Telephone: (_____) ______________ Contact: ______________ Title: ______________
(Person to contact concerning coverages)

No. of Eligible Employees : ______________ No. of Eligible Employees Enrolled: ______________

Effective Date Requested: ______________ SIC Code and Nature of Business: ______________
(The firm's effective date will be the first or the 15th of the month following written acceptance by Companion Life Insurance Company.)

How many years in this business? ______________ How many years at this location? ______________

Tax I.D. Number: ______________ No. of Family Members in Organization: ______________

PLAN DESCRIPTION

PLAN REQUESTED: ☐ Traditional ☐ Adult plus Child Wrap Plan ☐ Pediatric Essentials Health Benefit EHB Plan

☐ Plan A: I - 100% II - 80% III - 50% - $1,000 Annual Maximum** - $100 Lifetime Deductible** ☐ Ortho*

☐ Plan B: I - 100% II - 80% III - 50% - $1,000 Annual Maximum** - $50 Contract Year Deductible** ☐ Ortho*

** Applies only to Adults and Children age 19 to 26 if the Child Wrap or the Pediatric EHB is requested above. * Applies to Traditional Plans only

Are Takeover Benefits requested? ☐ Yes ☐ No If yes, please provide the following:

a. Name of Prior Carrier: ______________________________

b. Effective Date of Prior Plan: ______________ c. Termination Date of Prior Plan: ______________

Also, submit a copy of your previous insurance carrier's most recent billing statement as well as a certificate or letter of acceptance that shows the effective date of your policy along with a copy of your previous carrier's certificate, booklet or schedule of benefits. If prior carrier's bill does not include the effective date of each employee's coverage, please note this information next to each employee's name so we can give the correct credit for transfer of benefits.

Employment Waiting Period: ☐ 1 Month ☐ Other: ______________ (or as allowed by state law)
(No waiting period applies to those employed on the effective date.)

Coverage following the completion of the waiting period selected will be effective on the first or the 15th of the month only.

The employer agrees to contribute the following percentage of the cost of employee dental insurance for all covered employees ________% (25% required)

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.

Participation Agreement (Administered and underwritten by Companion Life Insurance Company)

The Participant hereby applies for Group Insurance Benefits as set forth in the above "Dental Employer Participation Application for the Joint Employer Group Insurance Trust" and subscribes to the Agreement and Declaration of Trust.

Name of Trust: The Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does the Trustee have any obligation under any policy of insurance and that all claims for and benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy(ies). The Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666.

____
(Signature of Employer/Applicant)

____
(Title) (Date)

This is to certify that I, the undersigned agent, have truly and accurately recorded on this application form the information supplied.

____
(Signature of Agent/Broker) (Date)

____
Print Agent/Broker's Name License No.

FOR HOME OFFICE USE

Accepted by Administrator Effective: ______________

By: ______________________________

____
(Title) (Date)