

UNITED CONCORDIA

APPLICATION FOR GROUP DENTAL INSURANCE

APPLICANT'S LEGAL NAME AND ADDRESS:		For general correspondence, receipt of billings and certificates: (If address is different than noted, place contact address on back)	
Name _____		Policymaker Name: _____	
Address _____		Title: _____	
		Phone: _____ Fax: _____	
		Email: _____	
		Group Administrator: _____	
		Phone: _____ Fax: _____	
		Email: _____	
NATURE OF BUSINESS:		INDUSTRY SIC CODE:	
Is Applicant exempt from ERISA? Yes <input type="checkbox"/> No <input type="checkbox"/>		Marketing Relationship: _____	

FFS PRODUCTS: FLEX: PREFERRED: SELECT: CHOICE: OTHER:

STANDARD OPTION: _____

COMPLETE THIS BOX FOR STANDARD OR NON-STANDARD OPTION.

	IN	OUT	STEP PLANS
Program Deductible: (Ind./Family) Deductible:	\$ ___/___	\$ ___/___	\$ ___/___
Program Max: Yr <input type="checkbox"/> Lifetime <input type="checkbox"/>	\$ _____	\$ _____	\$ _____
Ortho Max: Yr <input type="checkbox"/> Lifetime <input type="checkbox"/>	\$ _____	\$ _____	\$ _____
Deductible Max Period: Contract Year <input type="checkbox"/> Calendar Year <input type="checkbox"/> Lifetime <input type="checkbox"/>			
Deductible Applied to all Services: Yes <input type="checkbox"/> No <input type="checkbox"/>			
If No, Services Exempt from Deductible: Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Ortho <input type="checkbox"/>			
Waiting Periods (Mos.): Class I _____ Class II _____ Class III _____ Ortho _____			

PREMIUM PAYMENT PERIOD: Monthly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/>	GROUP EFFECTIVE DATE: (1st of month) ___/___/___	DEPENDENT COVERAGE INCLUDES: Spouse <input type="checkbox"/> Children <input type="checkbox"/> Non-Students to Age _____ Students to Age _____ Domestic Partners <input type="checkbox"/>
Premium must be paid in advance. Checks payable to United Concordia.	PRIOR COVERAGE: Yes <input type="checkbox"/> No <input type="checkbox"/> Carrier _____	

PARTICIPATION SUMMARY: _____ # Eligible employees _____ # Enrolled _____ # Waived _____ # Spouse Opt-Outs	FFS NETWORK REIMBURSEMENT: Advantage <input type="checkbox"/> Advantage Plus <input type="checkbox"/> National FFS <input type="checkbox"/> No Network <input type="checkbox"/> Access <input type="checkbox"/> Pricing -- In _____/Out _____
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RATES: Certificate Holder: _____ Certificate Holder & One Adult: _____ Certificate Holder & One Child: _____ Certificate Holder & Children: _____ Certificate Holder & Family: _____	RATE PERIOD: (MM/DD/YYYY) From _____ 12:01 AM (1st of month) To _____ 12:00 AM (Last day of month)
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ELIGIBILITY WAITING PERIOD:
New Certificate Holders are eligible for coverage on the _____ of the month following _____ days/mos in an eligible class, or other: _____.

United Concordia Life and Health Insurance Company
a wholly owned subsidiary of United Concordia Companies, Inc., {4401 Deer Path Road, Harrisburg, PA 17110}

THE APPLICANT REPRESENTS that: by signing this application, he/she agrees that the group dental insurance described above will become effective upon acceptance of this application by United Concordia (UC). Applicant further acknowledges that no coverage will be effective before the date determined by UC and only if the first Premium has been paid and underwriting bid qualifications are met. If this application is accepted, it becomes a part of the insurance contract between Applicant and UC. If this application is not accepted, any Premium advanced by the Applicant will be refunded.

Applicant represents that all information on this application is true and complete, and acknowledges that coverage may be rescinded if there are material misstatements on this application. If errors or omissions in this application are discovered by UC, it is authorized to amend this application by noting the changes on this form, except that no change in amount, classification, plan of insurance, or benefits may take effect unless agreed to in writing by the applicant. The acceptance, evidenced by Premium payment, of any Policy issued on this application, so amended, shall constitute a ratification of any such changes or amendments. Upon policy renewal date, payment of the renewal premium will confirm acceptance of that renewal for the subsequent rate period.

No agent or broker has the right to accept this application or bind coverage. Any first premium or application submitted to UC or its sales personnel by a non-appointed producer must be accompanied by completed appointment paperwork or it will be returned to the non-appointed producer.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime.

Applicant: _____ Dated at: _____
(Date) (City) (State)

By: _____ Producer: _____ SSN#: _____

Title: _____ Agency: _____ Tax ID: _____
UC Producer ID#: Agency _____ Producer _____