UNITED CONCORDIA
America's Premier Dental Insurer

APPLICATION FOR GROUP DENTAL INSURANCE

APPLICANT'S LEGAL NAME AND ADDRESS: (Street address only)

Name

Street

City State Zip

EFFECTIVE DATE OF COVERAGE: 1st of month

GROUP NUMBER: Company to complete

NATURE OF BUSINESS/INDUSTRY SIC CODE:

For general correspondence, receipt of billings and certificates:
(If address is different than noted, place contact address on back)

Policymaker Name: _____
Title: _____
Phone: _____
Fax: _____

Group Leader Name: _____
Phone: _____
Fax: _____

United Concordia Representative: _____

BENEFITS:

	FLEX: ☐	PREFERRED*: ☐ In-Network	PREFERRED*: ☐ Out-of-Network	SELECT: ☐ Year 1	SELECT: ☐ Year 2	SELECT: ☐ Year 3
Class I:	_____%	_____%	_____%	_____%	_____%	_____%
Class II:	_____%	_____%	_____%	_____%	_____%	_____%
Class III:	_____%	_____%	_____%	_____%	_____%	_____%
Ortho: Adult ☐	_____%	_____%	_____%	_____%	_____%	_____%
Deduct:	$_____	$_____	$_____	$_____	$_____	$_____
Max:	$_____	$_____	$_____	$_____	$_____	$_____
Year ☐ Lifetime ☐						
Ortho Max: $_____ Year ☐ Lifetime ☐		$_____	$_____	$_____	$_____	$_____

Deductible Period: Contract Year ☐ Calendar Year ☐ Lifetime ☐
Deductible Applied to all Services: Yes ☐ No ☐
Exempt from Deductible: Class I ☐ Class II ☐ Class III ☐ Ortho ☐
Waiting Periods (Mos.): Class I _____ Class II _____ Class III _____ Ortho _____

Service	Plan Pays IN	Plan Pays OUT
Exams	%	%
Bitewing Only x-rays	%	%
All X-rays or All Other X-rays	%	%
Cleanings	%	%
Fluoride Treatments	%	%
Sealants	%	%
Palliative Treatment	%	%
Space Maintainers	%	%
Basic Restorative	%	%
Endodontics	%	%
Non-Surgical Periodontics	%	%
Repairs of CIO, Bridges	%	%
Simple Extractions	%	%
Surgical Periodontics	%	%
Complex Oral Surgery	%	%
General Anesthesia	%	%
Inlays, Onlays, Crowns	%	%
Prosthetics	%	%
Orthodontics	%	%

RIDERS:	Implant ☐	TMD ☐	Domestic Partner ☐	Late Entrant ☐
Coinsurance:	%	%	Employee Only ☐	Explain:
Maximum:	$_____ Lifetime ☐ Program ☐	$_____ Lifetime ☐ Program ☐ Year ☐	Other ☐ (Explain)	
Waiting Period:	Mos._____	Mos._____		

Network: **Advantage** ☐ **NFFS** ☐ **N/A** ☐

PLUS/TC:** ☐ OTHER: ☐ (Explain on back)
Plan_____

EPO:*** ☐ OTHER: ☐ (Explain on back)
Plan_____

PREMIUM PERIOD (PREMIUM WILL BE PAID IN ADVANCE):
Monthly ☐
Quarterly ☐
Semi-Annually ☐
Annually ☐

All premium checks must be made payable to the Company.

RATE PERIOD:
From _____ 12:01 AM
(MM/DD/YYYY)
To _____ 11:59 PM
(MM/DD/YYYY)

EMPLOYER CONTRIBUTION LEVEL:
Employee _____% Dependent _____%

RATES:
Employee: _____
Employee & One Adult: _____
Employee & One Child: _____
Employee & Children: _____
Family: _____

PARTICIPATION SUMMARY:
_____ # of eligible employees
_____ # enrolled
_____ # covered under another plan

Please attach Enrollment Certification Form.

ELIGIBILITY SUMMARY:
Eligibility Waiting Period for Eligible Employees:
New employees are eligible for coverage on the _____ of the month following _____ days/mos of employment in an eligible class, or other: _____.

COVERAGE FOR DEPENDENTS:
Children to age _____
Students to age _____

HOW MANY HOURS PER WEEK DEFINES FULL-TIME EMPLOYMENT?: _____

* Preferred is not available in the following states: GA, LA, MS, NJ, TX and any other state where United Concordia does not have approval.
** Plus/TC is not available in the following states: AK, AR, DE, GA, IA, ID, LA, ME, MN, MS, MT, NE, ND NM, NV, NY, OK, OR, SD, UT, VT, WA, WV, WY and any other state where United Concordia does not have approval.
*** EPO available in limited states. EPOs are not permitted in TX.

Are any classes or locations excluded? Yes ☐ (Please explain below) No ☐

a) Classes, include reason for exclusion, e.g., employees covered by Dental HMO, Prepaid or Union which is excluded for benefits:

_____

b) Locations: (identify location, city and state): _____

Are any subsidiaries/affiliated companies to be insured? Yes ☐ (Please explain below) No ☐

_____

Prior Dental Coverage Yes ☐ No ☐ Name of Carrier(s): _____

Type of Plan(s): Fee-for-Service ☐ PPO ☐ POS ☐ EPO ☐ DHMO ☐

Policy Number(s):_____ Effective Date: _____ Termination Date: _____

THE APPLICANT REPRESENTS that: by signing this applicant, he/she agrees that the group dental insurance described above will become effective upon acceptance of this application by the Company. Applicant further acknowledges that no coverage will be effective before the date determined by the Company and only if the first Premium has been paid, and that no agent or broker has the right to accept this application or bind coverage. If this applicant is accepted, it becomes a part of the insurance contract between Applicant and the Company. If this application is not accepted, any Premium advanced by the Applicant will be refunded.

Applicant warrants 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 the Company, it is authorized to amend this application by noting the changes on this form, and 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 premium year.

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: _____
(City) (State)

By: _____ Agent/Agency: _____
(Date)

Title: _____ Tax ID/SS# and License #: _____

State Mandated Provisions

CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

FL: 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.

AZ & GA: All statements made by the Policyholder or by any insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.

KS: Any person who knowingly and with intent to defraud, as stated on this Application, maybe committing a fraudulent insurance act which maybe a crime.

KY: All statements made by the Policyholder or by any insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.

LA: 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 maybe subject to fines and confinement in prison.

NJ: All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OR: Any person who knowingly and with intent to defraud, as stated on this Application, maybe committing a fraudulent insurance act which maybe a crime.

OR: Contestability is limited to two years as stated in the Group Policy.

VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

United Concordia operates as a wholly owned subsidiary under the name listed below in the following states:

United Concordia Dental Corporation of Alabama - AL
United Concordia Dental Plans, Inc. - MD, NJ
United Concordia Dental Plans of Arizona, Inc. - AZ
United Concordia Dental Plans of California, Inc. - CA
United Concordia Dental Plans of Colorado, Inc. - CO
United Concordia Dental Plans of Delaware, Inc. - DE
United Concordia Dental Plans of Florida, Inc. - FL
United Concordia Dental Plans of Illinois, Inc. - IL
United Concordia Dental Plans of Kentucky, Inc. - KY
United Concordia Dental Plans of the Midwest, Inc. - IN, KS, MI, MO, OH
United Concordia Dental Plans of Pennsylvania, Inc. - PA
United Concordia Dental Plans of Texas, Inc. - TX
United Concordia Insurance Company - AK, AR, AZ, CA, CO, FL, GA IA, ID, IN, KS, LA, MD, ME, MI MN, MS, MT, NE, NV, NM, ND, OH, OK, OR, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY
United Concordia Life and Health Insurance Company - DE, DC, IL, KY, MD, MO, NJ, PA
United Concordia Insurance Company of New York - NY