



Group Dental New Business Guidelines

Washington

Selling Group Dental from the brochure:

1. Complete Group Master Application signed by employer and agent.
2. New Business Transmittal completed by the agent.
3. An enrollment card completed and signed by each person enrolling.
4. A check for the first month premium, if possible.
5. A Quarterly Wage & Tax Report is required for each Unique Edge plan sold.

Submitting a group with “takeover” benefits (either a Unique Edge plan with 25 or more enrollees; or a quoted voluntary group):

All of the above plus:

1. A copy of the most recent billing statement from the prior carrier.
2. The original effective dates with the prior carrier for each employee eligible for “takeover” benefits.
3. A copy of the prior carrier’s benefits.
4. A copy of the “takeover” quote, if quoted.

Documentation Requirements	Edge Plus Plan A	Edge Plus Plan B	Basic Plus	Unique Edge Plan A	Unique Edge Plan B
Group Master Application (signed by agent & officer of group)	X	X	X	X	X
New Business Transmittal (completed by agent)	X	X	X	X	X
Enrollment card for each enrollee (signed by employee)	X	X	X	X	X
Waiver of Coverage on back of enrollment card signed by employee when declining coverage				X	X
A check for the first month premium	X	X	X	X	X
Copy of last billing statement from prior carrier*	*	*		*	*
The original effective dates with the prior carrier for each enrollee*	*	*		*	*
A copy of the prior carrier’s benefits*	*	*		*	*
Most recent Quarterly Wage & Tax Report*				X	X
A copy of the quote, if applicable	X	X	X	X	X

*Only required when selling “takeover.”

AL 9-23-08



NEW BUSINESS TRANSMITTAL (Required with each new sale)

Home Office Use Only Group #

WRITING AGENT INFORMATION (Please Print)

Writing Agent, Agent Code #, Date, Address, City, State, Zip Code, Phone Number, Fax Number, E-Mail, Splitting Agent, Commission Split

GROUP INFORMATION (Please Print) New Additional Account

Name of Company/Group, Billing Address, City, State, Zip Code, Group Contact Name, E-Mail, Effective Date, Who is paying the premium?, Bill 1st Month Premium, Cash with applications: Total \$

GROUP DENTAL INSURANCE

of Enrollment Cards Attached, Area Rating, With Orthodontia, Without Orthodontia, Waive the Missing Tooth Clause, Increase Benefit Maximums, No Deductible Premier, A quarterly Wage & Tax Report is required for: Takeover requested?, This plan replaces existing coverage and "takeover" benefits are not requested, Section 125, Current COBRA participants are to be covered, I sold the following dental rates: Plan A, Plan B, Basic, TRIPLE COMBO, ACCI-DENTAL

ACCIDENTAL DEATH AND DISMEMBERMENT

of Applications Attached

VISION INSURANCE

INSURED VISION PLAN (VSP)* With Dental Stand Alone (Special rules apply)

***This vision coverage does not require a Master Application**

of Enrollment Cards Attached

Plan A: Employee Only \$ Employee & 1 Dependent \$ Employee & Family \$

Plan B: Employee Only \$ Employee & 1 Dependent \$ Employee & Family \$

Plan A & B Combo

Waiting Period

- 30 days
- 60 days
- 90 days
- Other: days

VSP VOLUNTARY VISION PLAN*: # of Enrollment Cards Attached

***This vision coverage does not require a Master Application**

Employee Only \$ Employee & 1 Dependent \$ Employee & Family \$

VOLUNTARY VISION PLAN (EYEMED): # of Enrollment Cards Attached

Employee Only \$ Employee & 1 Dependent \$ Employee & Family \$

AVESIS ADVANTAGE VISION PLAN: # of Enrollment Cards Attached

Voluntary With Dental 100% Participation

Employee Only \$ Employee & 1 Dependent \$ Employee & Family \$

LIFE INSURANCE

GUARANTEED ISSUE GROUP TERM LIFE

of Applications Attached A copy of the Employer's Quarterly Wage & Tax Report is required.

GUARANTEED ISSUE WITH ADDITIONAL COVERAGE GROUP TERM LIFE

of Applications Attached A copy of the Employer's Quarterly Wage & Tax Report is required.

HOSPITAL INDEMNITY PLAN

With AD&D Without AD&D

of Applications Attached

CARE 5000 CANCER

of Applications Attached

GROUP SHORT TERM DISABILITY

Industry Class: A B When was business established? Date:

of Applications Attached A copy of the Employer's Quarterly Wage & Tax Report is required.

ADDITIONAL INFORMATION

Agent Signature Date

IMPORTANT NOTICE
 All products are not approved in all states. Please check with the home office for product approval information in your state or check our Web Site: www.bnlac.com



Domiciled in the State of Arkansas
Administrative Office: 7010 Hwy 71 West, Suite 100, Austin, Texas 78735
Phone: 512-383-0220

APPLICATION FOR GROUP DENTAL INSURANCE BENEFITS

Application is hereby made to Brokers National Life Assurance Company for the following Group Dental Insurance.

- EDGE PLUS DENTAL BASIC PLUS DENTAL UNIQUE EDGE DENTAL *ASSOCIATION DENTAL

- 1. Group Name:
2. Policyholder is: Corporation Partnership Sole Proprietor Association Other
3. Group Address: Street Address or P.O. Box Number City State Zip Code
4. Group Contact: Telephone # Fax #
5. Nature of Group: 6. Payment Mode: Monthly Quarterly Semi-Annually Annually
7. Total Employees/Members Eligible 8. Number of Employees/Members Enrolled
9. It is requested that this insurance be effective on (The effective date must be the first of the month. All papers must be received by the Company in acceptable form by the requested effective date.)

10. All present employees are to be eligible on the effective date except part-time employees and those on disability leave. Employees who come to work after the effective date shall be eligible on the first day of the month following completion of days of continuous active service.

Every Group will have an Open Enrollment period, which is the group's policy anniversary date, unless otherwise changed.

- 11. The firm will pay % of all Employee costs and % of Dependent costs.
12. This (does does not) replace current coverage from another carrier. If coverage is being replaced, a current monthly billing from the prior carrier must be enclosed along with a benefit booklet.
13. I hereby represent that there are, as of this date, a total of full-time eligible employees including owners, partners, and officers in the employment of this firm. If any class or classes of employees are to be excluded from eligibility describe them briefly. (Such class exclusion must be nondiscriminatory.) (Not Applicable for Association Groups.)

It is understood & agreed that: 1. There must be a minimum of 3 employees (or 50 members for Associations) participating at all times and that failure to maintain this minimum may result in the termination of all coverage at the discretion of the Company by giving the Group 30 days written notice (In Florida - 45 days). 2. Investigation(s) may be made now and in the future, by or on behalf of the Company to verify the number and names of full-time employees of this firm, and will furnish, upon request, a current census prior to each anniversary date. 3. If, on the effective date, an employee is not at active work full-time, or a dependent is unable to maintain dependent status, coverage will not be given until the employee or dependent returns to an active eligibility status. 4. The insurance applied for shall not become effective unless this application is received and approved by Brokers National Life Assurance Company, at its administrative office, and the required premiums are paid. 5. No person (except an authorized Officer of Brokers National Life Assurance Company) has authority to modify, or vary any policy or to waive any requirement in any policy.

Any person who, with 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 is guilty of insurance fraud. (Except in Colorado, Florida, Georgia, Kansas, Kentucky, Louisiana, Nebraska, Oregon, Pennsylvania, Tennessee, Texas & Washington) In Colorado, it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. In Florida, 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. In Georgia, Nebraska, Oregon & Texas, any person who, with 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 be guilty of insurance fraud. In Kansas, any person who, with 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 be guilty of insurance fraud, as determined by a court of law. In Kentucky, 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. In Louisiana, any person who knowingly presents 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 fines and confinement in prison. In Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. In Tennessee, it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. In Washington, any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

Dated at this day of , 20
Signature of Applicant X Title
Witness X
Licensed Agent X Agent License I.D. #
Print Writing Agent Name Agent #
Print Splitting Agent Name Agent #

*Association Dental Plan not allowed in the state of Oregon
GR-DEN-APP(2001).6



BROKERS NATIONAL LIFE ASSURANCE COMPANY

GROUP DENTAL INSURANCE ENROLLMENT CARD

NAME OF EMPLOYER _____						GROUP # _____			
EMPLOYEE NAME LAST _____ FIRST _____ MIDDLE _____						<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE			
HOME ADDRESS STREET _____ CITY _____ STATE _____ ZIP CODE _____									
HOME TEL. NO. () _____		DATE OF BIRTH / / _____		SOCIAL SECURITY NUMBER _____		EMPLOYMENT DATE _____			
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		(CHECK ONE): <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE AND ONE DEPENDENT <input type="checkbox"/> EMPLOYEE AND FAMILY				WORK 30 HOURS PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
LIST NAME, SEX AND DATE OF BIRTH OF EACH DEPENDENT YOU WISH TO INSURE STUDENT VERIFICATION MUST ACCOMPANY DEPENDENTS OVER 19.									
NAME		REL.	SEX	DATE OF BIRTH	NAME		REL.	SEX	DATE OF BIRTH
DOES YOUR SPOUSE HAVE OTHER COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS THE AMOUNT TO COVER MY SHARE OF THE CONTRIBUTION FOR COVERAGE INDICATED ABOVE. <small>*PROVISIONS ON THE REVERSE SIDE ACCEPTED</small>				<input type="checkbox"/> EMPLOYER PAID <input type="checkbox"/> EMPLOYEE PAID			
SIGNATURE OF EMPLOYEE _____		DATE _____		REQUESTED EFFECTIVE DATE _____		(CHECK ONE): <input type="checkbox"/> PLAN A <input type="checkbox"/> PLAN B <input type="checkbox"/> BASIC			

IL-GA-1705(08/91).4

DOMICILED IN THE STATE OF ARKANSAS • ADMINISTRATIVE OFFICE: 7010 HWY 71 WEST, STE. 100, AUSTIN, TEXAS 78735 • PHONE: 512-383-0220

I hereby apply to BROKERS NATIONAL LIFE ASSURANCE COMPANY for Group Dental Insurance as presented to me and authorize my employer to make any necessary deduction from my salary to pay the premium when my insurance becomes effective.

I further represent that I am not presently disabled and I am performing all the duties of my occupation at least 30 hours per week.

WAIVER OF COVERAGE

I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR GROUP DENTAL INSURANCE, BUT:

- DO NOT WISH THIS COVERAGE.
- AM COVERED UNDER SPOUSE'S DENTAL PLAN WITH _____
Name of insurance company

Dated this _____ day of _____, 20____, _____
Individual's Signature

For Home Office Use Only

Plan _____ State _____ FR# _____ EPSI# _____ WP _____ OE _____ Effective Date _____	1 / 15
Notes:	

Writing Agent Name _____ Agent # _____

Splitting Agent Name _____ Agent # _____

Please submit completed forms to:
 Matrix Insurance Marketing, Inc.
 1225 S Weller St, Ste 320, Seattle, WA 98144
 Ph: 206-521-9451 or 800-929-6123
 Fax: 206-521-9554
 Email: info@matrixinsurance.com