



Dental by Design Checklist

- Completed Employer Application for Group Dental Insurance (Form #95187)**
- Group Insurance Enrollment Form (Form #95206) completed by each full-time employee**
- Proof of Prior Coverage (For takeover groups only)**
 - Evidence that the prior carrier's coverage has been in force for at least 12 months prior to the effective date
 - A copy of the most recent bill that includes a listing of all covered employees with their effective dates noted (This item is not required for Preferred Takeover)
 - A copy of the in-force dental plan (contract, certificate or booklet)
- Group check for one month's premium payable to: Companion Life Insurance Company**
- Copy of the sold dental proposal**

Mail all of the above items directly to:

Matrix Insurance Marketing, Inc.

1225 S. Weller St. Suite 320

Seattle, WA 98144

(206) 521-9451

(800) 929-6123

info@matrixinsurance.com

EMPLOYER APPLICATION FOR GROUP DENTAL INSURANCE

dental by design
A COMPLETE DENTAL INSURANCE PORTFOLIO FROM COMPANION LIFE.



Companion Life Insurance Company • PO Box 100102 • Columbia, South Carolina 29202-3102
1-800-753-0404 • FAX (803) 735-0736

Please Print or Type

EMPLOYER INFORMATION

1. Full legal name of applicant (As it should appear in policy)		Telephone Number ()	
2. Applicant's Federal Tax ID Number			
3. Address	Street	Post Office Box	ZIP
City		County	State
4. Administrative Correspondence with the Applicant should be addressed to: Name _____ Title _____			
5. Nature of Business		6. Requested Effective Date:	
7. Are there subsidiary businesses covered under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please state name and nature of each subsidiary or affiliate.	
Are separate billings required? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please provide billing instructions.	
8. Type of Administration:		<input type="checkbox"/> Home Office Administered	<input type="checkbox"/> Self Administered

EMPLOYEE ELIGIBILITY

9. The normal work week for full-time employees must be at least 30 hours unless otherwise approved by Companion Life.	
10. Current eligible employees are to be covered: <input type="checkbox"/> Immediately on the requested effective date. <input type="checkbox"/> After _____ days of continuous employment. <input type="checkbox"/> First of the month following _____ days of continuous employment.	11. Employees hired after the plan effective dates are to be covered: <input type="checkbox"/> Immediately. <input type="checkbox"/> After _____ days of continuous employment. <input type="checkbox"/> First of the month following _____ days of continuous employment.
12. Coverage following completion of the waiting period selected will be effective the first of the month following completion of the waiting period or the next billing date.	
13. Number of Eligible Employees: _____	14. Number of Enrolled Employees: _____

SPECIFICATIONS FOR INSURANCE

15. Percent of Premium Paid by Employer: <input type="checkbox"/> Single/Employee Only <input type="checkbox"/> Family/Employee & Dependents _____%		
16. Will this coverage replace any existing dental insurance plan? If YES, name present insurance carrier: <input type="checkbox"/> Yes <input type="checkbox"/> No		
17. Existing Plan Effective Date:	18. Termination Date of Existing Plan	19. Check coverages being replaced: <input type="checkbox"/> Preventive <input type="checkbox"/> Basic <input type="checkbox"/> Major <input type="checkbox"/> Orthodontia
20. Is prior insurance credit (takeover benefits) requested? <input type="checkbox"/> Yes <input type="checkbox"/> No		
21. The following documentation is required when prior insurance credit is requested. Your current dental plan must have been in effect continuously for at least 12 months prior to effective date. <ul style="list-style-type: none">• 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 employees.• A list of the covered employees with the prior carrier which includes the employee's effective dates of coverage.• A copy of the inforce dental plan which may be a contract, certificate, or booklet.		

Select Your *dental by design* Program On the Reverse

22. Select Standard Benefit Design (REQUIRED)	<input type="checkbox"/> Dental Essentials	<input type="checkbox"/> Dental Choice	<input type="checkbox"/> Dental Select
Program Deductible (all services)	\$100 Lifetime	\$100 Lifetime	\$100 Lifetime
Type I – Preventive Services	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants, full mouth X-rays
Type II – Basic Services (Waiting Period)	80% space maintainers, fillings, treatment, sealants, full mouth X-rays None	80% full mouth X-rays, fillings, simple extractions, endodontics None	80% fillings, anesthesia, simple & surgical extractions, endodontics, oral surgery, periodontics None
Type III – Major Services (Waiting Period)	50% anesthesia, endodontics, simple & surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants 12 months	50% anesthesia, surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants 12 months	50% crowns, inlays, onlays, dentures, bridges, implants 12 months
Contract Year Maximum	\$1,000	\$1,200	\$1,500
Type IV – Orthodontia \$1,000 Lifetime Orthodontial Maximum Deductible (Waiting Period)	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months
Takeover Benefit	Preferred	Preferred	Preferred

23. **NO DESIGN OPTIONS – Issue Standard Benefit Design (above)**

– OR –

24. Choose Design Options (if any) (below)	Dental Essentials	Dental Choice	Dental Select
Incentive Plan – Percentage Increases in 2 nd and 3 rd years; No Waiting Periods Apply; Incentive Plan Takeover Only; If Selected, Child Orthodontia Max is \$375 annually and \$1,000 Lifetime	<input type="checkbox"/> Yes <input type="checkbox"/> No 1 st yr./2 nd yr./3 rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%	<input type="checkbox"/> Yes <input type="checkbox"/> No 1 st yr./2 nd yr./3 rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%	<input type="checkbox"/> Yes <input type="checkbox"/> No 1 st yr./2 nd yr./3 rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%
Contract Year Deductible Amount per Individual Limit Per Family Waive Deductible for Type I Services? (N/A for Lifetime Deductible)	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequency of Cleanings / Exams	<input type="checkbox"/> 1 per 12 months	<input type="checkbox"/> 1 per 12 months	<input type="checkbox"/> 1 per 12 months
Frequency of Bitewing X-Rays	<input type="checkbox"/> 2 per 12 months	<input type="checkbox"/> 2 per 12 months	<input type="checkbox"/> 2 per 12 months
Change the Contract Year Maximum	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$2,000
Add Retiree Dental Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change the Premium Rate Structure (Standard is Four Tiers)	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Three Tiers	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Three Tiers	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Three Tiers

THE FOLLOWING DESIGN OPTIONS ARE NOT AVAILABLE WITH THE INCENTIVE PLAN:

Change Coinsurance	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50
Add a Type II Waiting Period Six Month Wait for Fillings Only	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes
Change the Type III Waiting Period	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months
Increase the Contract Maximum by \$250 per Year Maximum Cap after Increases \$2,500/yr.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases
Change the Orthodontia Option Orthodontia Lifetime Max Orthodontia Waiting Period Adult Orthodontia	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No
Takeover Option	<input type="checkbox"/> Standard Takeover	<input type="checkbox"/> Standard Takeover	<input type="checkbox"/> Standard Takeover

EMPLOYER'S SIGNATURE

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.

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.

Dated at _____ this _____ day of _____, 20 _____
City/State

Signature of Employer Title Witness

AGENT'S REPORT

25. Initial Deposit (Minimum first month's premium is required.) 26. Agent/Broker Name (Please Print) Telephone Number
\$ ()

27. Address Post Office Box

City County State ZIP

28. Are there other group insurance plans which duplicate 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 purposes of these plans:

29. Is Agent or Broker licensed and appointed by Companion for the types of insurance solicited where this group is located?
 Yes No Agent Code Number _____ State License _____

30. Signature of Agent/Broker _____ Date _____

**Please submit completed forms to:
Matrix Insurance Marketing, Inc.
1225 S. Weller St. Suite 320 Seattle, WA 98144
Phone (206)521-9451 Fax (206)521-9554
info@matrixinsurance.com**



www.CompanionLife.com

**GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST**



Please submit completed form to:
Matrix Insurance Marketing, Inc.
1225 S. Weller St. Suite 320 Seattle, WA 98144
Phone (206)521-9451 Fax (206)521-9554
info@matrixinsurance.com

- | | |
|--|--|
| <input type="checkbox"/> New Employee | <input type="checkbox"/> Change Address |
| <input type="checkbox"/> Add/Increase Coverage | <input type="checkbox"/> Change Dependent Coverage |
| <input type="checkbox"/> Change Beneficiary | <input type="checkbox"/> Change Class or Status |
| <input type="checkbox"/> COBRA | <input type="checkbox"/> Terminate Coverage |

Companion Use Only
Approved: Declined:
Date: _____
By: _____

TO BE COMPLETED BY EMPLOYER		Group No. (10 digit #)	DEPT/DIV (3 digit #)	CLASS
Name of Employer (Use Name from Group Billing Notice or Master Application)				

TO BE COMPLETED BY EMPLOYEES												
Social Security Number			Effective Date			Date Employed Full Time			Date of Birth			Hours Worked Per Week
			Month	Day	Year	Month	Day	Year	Month	Day	Year	
Your Name	Last	First	M.I.	Sex	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually (Do not include over-time or bonuses.)							
				<input type="checkbox"/> Female <input type="checkbox"/> Male	Earnings \$ _____							
Marital Status	Occupation	Your Home Address			City	State	Zip Code					
<input type="checkbox"/> Single <input type="checkbox"/> Married												

COMPLETE FOR LIFE AND/OR DISABILITY									
COVERAGE REQUESTED <input type="checkbox"/> Basic Life Insurance <input type="checkbox"/> AD&D <input type="checkbox"/> Dependent Life Insurance <input type="checkbox"/> Short Term Disability									
<input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary LTD									
<input type="checkbox"/> Voluntary Life	Life	AD&D	Life	AD&D	Life	AD&D	Life		
(Amount Selected)	EMPLOYEE: \$ _____	\$ _____	SPOUSE: \$ _____	\$ _____	CHILD: \$ _____				
Spouse Name:	Last	First	Middle	Birthdate	Social Security Number				
<i>(Voluntary Life Only)</i>									
Beneficiary for Employee Coverage/Relationship: <i>(Employee is beneficiary for spouse coverage.)</i>									
Last	First	Middle	Relationship to Insured						

COMPLETE FOR DENTAL AND/OR VISION									
Coverage Requested: <input type="checkbox"/> Dental For Employee Only <input type="checkbox"/> Dental For Employee and Dependents									
<input type="checkbox"/> Vision For Employee Only <input type="checkbox"/> Vision For Employee and Dependents									
Is your spouse to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental and/or Vision Coverage Is For (Check Box Below):							Are you or any of your dependents covered for dental insurance under another policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee plus Spouse	<input type="checkbox"/> Employee plus Child(ren)	<input type="checkbox"/> Family					

Complete for Dependent Coverage				Full-time Student Y/N	Date of Birth	Gender M or F	Do any of your dependents have any other dental coverage?	If Yes, Name of Carrier
Spouse Name	(Last)	(First)	(Middle Initial)		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
CHILDREN	1				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4				/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

REFUSAL OF GROUP INSURANCE									
I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.									
Coverage Refused (Check All That Apply): <input type="checkbox"/> Basic Life <input type="checkbox"/> AD&D <input type="checkbox"/> Dependent Life <input type="checkbox"/> Voluntary Life									
<input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary LTD <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Dental									

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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.

Date	Your Signature
	x

NOTICE TO PROPOSED INSURED – DETACH AND GIVE TO PROPOSED INSURED

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.