



## **Dental Cents Checklist**

- Completed Dental Employer Participation Application (Form #95078)**
- 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
  - 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 (Please be sure to include the \$15 monthly billing fee)**
- 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](mailto:info@matrixinsurance.com)**



# 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:**

- |                                  |          |          |           |   |  |
|----------------------------------|----------|----------|-----------|---|--|
| <input type="checkbox"/> Plan A: | I - 100% | II - 80% | III - 50% | - | \$1,000 Annual Maximum - \$100 Lifetime Deductible     |
| <input type="checkbox"/> Plan B: | I - 100% | II - 80% | III - 50% | - | \$1,000 Annual Maximum - \$25/\$50 deductible          |
| <input type="checkbox"/> Plan C: | I - 100% | II - N/A | III - N/A | - | \$1,000 Annual Maximum - \$15 copay per visit          |
| <input type="checkbox"/> Plan D: | I - 100% | II - 80% | III - 50% | - | \$1,000 Annual Maximum - \$50 Contract Year Deductible |

Are Orthodontia Benefits requested? (Plans A, B and D only)  Yes  No

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: \_\_\_\_\_  
(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)

**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: \_\_\_\_\_

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

<b>TO BE COMPLETED BY EMPLOYEES</b>												
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												

<b>COMPLETE FOR LIFE AND/OR DISABILITY</b>									
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						

<b>COMPLETE FOR DENTAL AND/OR VISION</b>									
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					

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

<b>REFUSAL OF GROUP INSURANCE</b>									
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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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.