Voluntary Dental Checklist

- ☐ **Completed Voluntary Dental Insurance Employer Participation Application (Form #95118)**
- ☐ **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 $10 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

Rev. 12/09

Companion Life
Companion Life Insurance Company/Columbia, SC

VOLUNTARY DENTAL INSURANCE EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

EMPLOYER (APPLICANT) INFORMATION (Please Print or Type)

Legal Name of Employer: ______

Address: ______ City: ______ State: ______ Zip: ______

Telephone: (______) ______ Contact: ______ Title: ______
(Person to contact concerning coverage)

No. of Eligible Employees: ______ No. of Eligible Employees Enrolled: ______

Effective Date Requested: ______ SIC Code and Nature of Business: ______
(The effective date will be the first or 15th day of the calendar month coinciding with or next following the date of written acceptance by Companion Life.)

How many years in this business? ______ How many years at this location? ______

Tax I.D. No.: ______ No. of Family Members in Organization: ______

PLAN REQUEST: VOLUNTARY INDEMNITY GROUP DENTAL

☐ Companion Premier Plan (Basic, Preventive and Major Services)
☐ Companion Premier Plan (Basic, Preventive, Major and Orthodontic Services)
☐ Advantage Plan (Basic, Preventive and certain Major Services)

TAKEOVER BENEFITS: Apply only if prior plan was group, employee-paid dental coverage.
In order for Companion Life to determine whether or not Takeover Benefits are to be included, the following must be provided:

a. Name of Prior Carrier: ______

b. Effective Date of Prior Plan: ______ c. Termination Date of Prior Plan: ______

The employer must also submit a copy of (1) the prior carrier's most recent billing statement; (2) a certificate or letter of acceptance that shows the effective date of the prior plan; and (3) the prior 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.

The normal work week for full-time employees is ______ hours.
Eligibility: All regular full-time employees working a minimum of ______ hours.
(The minimum work week for full-time employees to be eligible for benefits is 30 hours.)

Employment Elimination Period: ☐ 1 Month ☐ Other: ______
(No elimination period applies to those employed on the efffective date.)
(Coverage following completion of the waiting period will be effective on the first or 15th day of the calendar month only.)

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 Employer hereby applies for Group Insurance Benefits as set forth in the above "Voluntary 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 the 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)

______
(Signature of Resident Agent/Broker) (Date)

______
Print Agent's/Broker's Name License No.

FOR HOME OFFICE USE ONLY

Employer Group No.: ______
Takeover Benefits: ☐ Yes ☐ No

Accepted by Companion Life 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

☐ New Employee ☐ Change Address
☐ Add/Increase Coverage ☐ Change Dependent Coverage
☐ Change Beneficiary ☐ Change Class or Status
☐ COBRA ☐ Terminate Coverage

Companion Use Only
Approved: ☐ Declined: ☐
Date:___________________
By:_____________________

TO BE COMPLETED BY EMPLOYER

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

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 ☐ Female ☐ Male | ☐ Weekly ☐ Monthly ☐ Annually Earnings $________________ (Do not include over-time or bonuses.)

Marital Status ☐ Single ☐ Married | Occupation | Your Home Address | City | State | Zip Code

COMPLETE FOR LIFE AND/OR DISABILITY

COVERAGE REQUESTED ☐ Basic Life Insurance ☐ AD&D ☐ Dependent Life Insurance ☐ Short Term Disability
☐ Long Term Disability ☐ Voluntary LTD

☐ Voluntary Life (Amount Selected) EMPLOYEE: Life $ AD&D $ SPOUSE: Life $ AD&D $ CHILD: Life $

Spouse Name: (Voluntary Life Only) Last First Middle | Birthdate | Social Security Number

Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage.)*
Last First Middle Relationship to Insured

COMPLETE FOR DENTAL AND/OR VISION

Coverage Requested: ☐ Dental For Employee Only ☐ Dental For Employee and Dependents
☐ Vision For Employee Only ☐ Vision For Employee and Dependents

Is your spouse to be covered? ☐ Yes ☐ No

Dental and/or Vision Coverage Is For (Check Box Below): ☐ Employee ☐ Employee plus Spouse ☐ Employee plus Child(ren) ☐ Family

Are you or any of your dependents covered for dental insurance under another policy? ☐ Yes ☐ No

Complete for Dependent Coverage (Last) (First) (Middle Initial)	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		/ /		☐ Yes ☐ No	
CHILDREN 1		/ /		☐ Yes ☐ No	
2		/ /		☐ Yes ☐ No	
3		/ /		☐ Yes ☐ No	
4		/ /		☐ Yes ☐ 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): ☐ Basic Life ☐ AD&D ☐ Dependent Life ☐ Voluntary Life
☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary LTD ☐ Dental ☐ 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.