SPIRIT DENTAL®

NEW BUSINESS CHECKLIST

Please confirm that the following information is submitted with all new cases:

☐ **Completed Employer Application**

- ☐ Complete the entire application and be sure to pay special attention to fields marked in YELLOW
- ☐ Employer AND agent MUST sign and date application

☐ **Completed Employee Application**

- ☐ Complete the entire application and be sure to pay special attention to fields marked in YELLOW
- ☐ Social Security Number
- ☐ Birthdate
- ☐ Marital Status
- ☐ Date of Hire
- ☐ If adding Domestic Partner as dependent you MUST submit completed and signed Domestic Partner Form
- ☐ Employee MUST sign and date application

☐ **First Month Premium (payable to Security Life Insurance Company of America) plus $15 Monthly Billing Fee (waived if paying via ACH bankdraft)**

- ☐ Account Holder MUST sign and date ACH Bankdraft application if applicable. Fields marked in Yellow are required to process your application in a timely manner.

Take Over Benefit Coverage

(Must provide the following documentation if group was enrolled with a prior carrier)

☐ **Copy of Prior Carrier's Certificate, Booklet, or Schedule of Benefits**

☐ **Copy of Prior Carrier's Most Recent Billing Statement**

Please submit all completed and signed paperwork to:

Matrix Insurance Marketing, Inc.
1225 So. Weller St., Suite 320
Seattle, WA 98144
Phone: 206.521.9451
Fax: 206.521.9554

Important Information

***New group applications should be postmarked no later than the end of the month to be effective by the first of the following month.**

***Please allow approximately a 2-3 week maximum from the time Matrix receives your application to the time your application is complete and policy is effective.**

***Please be aware that Meritain Health is the Plan Administrator.**

EMPLOYER ELECTION FORM

Please mail completed form to:
Matrix Insurance Marketing
1225 S. Weller St. - Suite 320
Seattle, WA 98144
(800) 929-6123 / (206) 521-9554 Fax

EMPLOYER INFORMATION

Legal Name of Employer_________________________ Send Correspondence to ____________________
Address ____________________________ City __________ State________Zip Code ______________
Phone Number (   ) ________________________ Fax (   ) ______________________________
Nature of Business ________________________ Email Address for Contact Person_________________
Subsidiaries and Affiliates Included [   ] Yes [   ] No
Name and Address of Subsidiaries & Affiliates whose employees are to be covered: ________________
Effective Date of Employer Participation:______________________

Class of Employees:

Regular full-time Employees working [   ] or more hours per week.

[   ] All Employees [ ] All regular full-time Employees

[   ] All Employees, except ______________________________

Employees must be actively at work on Effective Date of coverage, if not, coverage will be effective on the First day of the month following return to active employment.

Employee Waiting Period:

Waiting Period (current Employees): [   ] Effective Date [   ] 1 month [   ] other ____________

Waiting Period (new Employees): [   ] 1 month [   ] 2 months [   ] other ____________

New Employees are covered on the first day of the month following the Waiting Period.

Premiums:

Dental Employee: $_________ Employee/One Dependent: $_________ Employee/Family: $_________

PLAN SELECTION

DENTAL ADOPTION AND PARTICIPATION AGREEMENT

[   ] 75% PARTICIPATION [   ] EMPLOYER VOLUNTARY

[   ] 2-4 Employees [   ] 5-9 Employees [   ] 10-149 Employees

Coverage Options*:

[   ] Increase Calendar Year Maximum to $2000 (premium x 1.15)
[   ] $50 Calendar Year Deductible (premium x 1.04)
[   ] Increase Calendar Year Maximum to $1500 (premium x 1.10)
[   ] With Orthodontia (premium –see rates)
[   ] Endodontics/Periodontics covered under Class B (premium x 1.13)
[   ] Take Over Credit-CPT (premium x1.10) ***Employer Voluntary Only***

____

*** Premiums must be adjusted accordingly**

There are initially ____ full-time employees of which ____ are enrolled in this Plan.

The undersigned Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under Group Dental Policy GH-1112-37740-2 insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

Authorized Signature ______________________________

Date ____________________ E-Mail ______________

VISION NOT AVAILABLE IN WASHINGTON STATE

PRODUCER'S STATEMENT – I hereby certify that all the information contained in this Employer Election Form is correct to the best of my knowledge and I know nothing unfavorable about this entity or any individual proposed for participation. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the entity.

(Please Print)

Producer Name ________________________ SS#/TIN#_________________ Appointed with Security Life? [   ] Yes [   ] No
Street Address __________________________________ City ____________________State _______ Zip ________
Phone Number _______________ Email ____________________ Agent Signature __________________________

Spirit Dental/Vision Enrollment Card

Return completed form to your employer

☐ Indemnity

Employer Information (TO BE COMPLETED BY THE EMPLOYER)

Name and Address of Employer or Organization (if applicable)	Full-Time Hire Date
	Telephone Number

FOR COMPANY USE ONLY

Effective Date: ____/____/____

Plan Code:________________

Group #/ Division ___________

CPT: ____________

Employee Information (PLEASE PRINT CLEARLY)

Coverage Election: ☐ Dental Only ☐ Decline Coverage

I apply for coverage on: ☐ Employee Only ☐ Employee +1 ☐ Employee and Family

Last Name	First Name	Initial	SS #
Address	Telephone Number		
City		State	Zip

Birth Date: / /

Sex: M [ ] F [ ]

Marital Status

Married [ ] Single [ ]

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

Please note: If additional dependent information is necessary please attach a separate sheet of paper.

1. Does Spouse have a dental plan? Yes ☐ No ☐
2. Do you claim a tax exemption for all eligible dependents listed above? Yes ☐ No ☐

With whom? ____ If no, who is not? ____

If answer is "Yes", are dependents enrolled under spouses plan? Yes ☐ No ☐

3. All dependent children above over age 18 are full time students. Yes ☐ No ☐

If not, who is not? ____

Group Dental Coverage is provided under the Group Dental Insurance Policy GH-1112 issued to the Employers' Voluntary Benefit Insurance Trust insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

Group Vision Coverage is provided under the Group Vision Policy GH-1157 or under the Group Vision Policy GH-1154 issued to the Group Policyholder (policyholder may be a trusteed group policyholder in some states) insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

By my signature below, I hereby apply for the coverage or coverage's selected above. I certify that I have read the applicable Fraud Notice below. I also hereby authorize payroll deductions from my earnings for any contributions required. This Authorization remains in effect until revoked by me in writing.

California Law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

____ ______________________________

Employee Signature Date

IMPORTANT FRAUD NOTICES

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 may be subject to fines and confinement in prison.

STATE SPECIFIC NOTICES

Arkansas/ Louisiana - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 policy holder 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.

District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky - Any person who knowingly and with intent to defraud any insurer 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.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Mexico - 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 may be subject to civil fines and criminal penalties.

Ohio - 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.

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 the 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.

Tennessee/Virginia - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

CERTIFICATION OF DOMESTIC PARTNERSHIP

We, the undersigned individuals, hereby certify under penalty of perjury that:

we are both at least 18 years old and are each mentally competent to give this Certification;

we are each other's sole domestic partner and intend to remain so indefinitely;

we currently reside together in the same household, have done so for at least 12 months, and intend to continue to do so indefinitely;

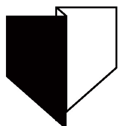
neither of us is married to another person;

we are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which we reside; and

we have mutually agreed to be responsible for each other's common welfare, basic living expenses, and financial obligations (debts) to third parties.

______________________	______________________
Employee's Signature	Domestic Partner's Signature
______________________	______________________
Employee's Name (Printed)	Domestic Partner's Name (Printed)
______________________	______________________
Date	Date
______________________	______________________
Disinterested Witness	Disinterested Witness

S10230(9/97)


MERITAIN[SM] HEALTH

Authorization to honor checks drawn or automatic debit entries made by Meritain Health 400 Highway 169 South, Suite 800 Minneapolis, MN 55426-1141

Name of bank: ______________________________
(Include branch name if applicable)

Address of bank/branch: ______________________________

Bank routing number: ____________________ **Account number:** ____________________

Account type: ☐ **Checking** (please attach a voided check) ☐ **Savings**

Print name of bank depositor/account holder: ______________________________

For the purpose of paying premiums on the policies or contracts listed below:

Policy or contract no.: ______________________________

Name of insured: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Indemnification agreement

To the bank named above:
In consideration of your participation in the arrangement authorized by your depositor in this document hereof, whereby amounts payable to this company are collected by checks drawn or automatic debit entries made by the company on the account of the depositor, Meritain Health hereby agrees:

1) Meritain Health will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn or automatic debit entry made by Meritain Health on the account of such person, or arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such check drawn or automatic debit entry made by Meritain Health, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy or contract of insurance, the premium on which is sought to be collected by Meritain Health, by any such check or automatic debit entry, and
2) Meritain Health will refund to you any amount erroneously paid by you on any such check or automatic debit entry if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check or automatic debit entry on which such erroneous payment was made.

If your participation in this arrangement is to be terminated, the company requests 30 days written notice to be sent to its Executive Office, 400 Highway 169 South, Suite 800, Minneapolis, MN 55426-1141.

Vice President Claims

Bank depositor/Account holder authorization

I hereby authorize Meritain Health to draw checks or make withdrawals by automatic debit each month on this account. Funds will be withdrawn on the policy or contract due date.
I agree that the presentation of such check or automatic debit to such bank shall constitute due notice of premium being due upon the said policies or contracts.
I agree that if any withdrawal for the payment of premiums is dishonored, or if the amount has been refunded to the bank upon its request, the payment shall be considered to be in default and if payment of the premium in default is not made within 31 days of the date on which such premium was due, the policy or contract shall terminate except as may otherwise be provided therein.
I agree that this arrangement may be discontinued by either of us for any reason at any time upon written notice to the other. On or after such discontinuance, premiums shall be payable as provided in the policy or contract and at the company's rate for the method of payment selected.
I hereby authorize the bank listed above to honor and charge to my account checks drawn or automatic debit entries made on my account by and payable to Meritain Health. The signatures on such checks may either be typed or printed. The bank shall have no liability for the return unpaid of any such check or automatic debit entry if the balance in my account is insufficient to pay the same upon presentation. I further agree that if any such check or automatic debit entry be dishonored, the bank shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization shall continue in force until revoked by me in writing.

00140-1205

______________________________ ______________
(Signature of Bank Depositor/Account Holder) (Date)

[ ] Monthly Credit Card

If choosing to pay by credit card, you must complete and sign the Authorization Agreement form below.

AUTHORIZATION AGREEMENT:

I hereby authorize Meritain Health to initiate entries to my credit card account. This authorization shall remain in full force until company has received advance written notification from me to terminate. I agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, the credit card company and Meritain Health shall be under no liability whatsoever even though it might result in forfeiture of my insurance. I understand that I have the right to stop payment by notification to Meritain Health, at least ten business days prior to the next scheduled payment.

Name of Financial Institution ______________________________

[ ] Visa [ ] Master Card

Card #______________________________

Expiration Date__________/________/__________

Name:______________________________

Signature:______________________________

Date:______________________________

Employer Request for Interactive Services

Authorized Web Users

Please submit completed form to:
Matrix Insurance Marketing, Inc.
1225 So. Weller St., Suite 320
Seattle, WA 98144
Phone: 206.521.9451
Fax: 206.521.9554
Email: info@matrixinsurance.com

I request the folowing employee(s) be provided with access to our Employer Group information available through the employer portal on www.meritain.com:

Name:
Email Address:
Phone Number:
Title:

Name:
Email Address:
Phone Number:
Title:

Name:
Email Address:
Phone Number:
Title:

Name:
Email Address:
Phone Number:
Title:

Employer Name (please print): ____________________________ Meritain Health Group# : ____

Authorized Individuals Name (please print) ____

Authorized Individual Signature: ____

Email Address of Authorized Individual: ____

Date: ____ / ____ / ____

We will contact you via email with additional instructions and information.

Administered by:

Mailing Address: Meritain Health 400 Highway 169 South Suite 800 Minneapolis, MN 55426	Phone Number: (952) 541-0444; (800) 765-4224 Fax: Number: (952) 593-3711 (Changes, terms and Adds) Email: FINewbusiness@meriitain.com

"Employee/Participant Questions regarding Spirit Dental Plans"

What is my group number? The group number is on the first page of the dental Certificate of Coverage and on the identification (ID) card.

Who shall I call with questions? Call Meritain Health at (952)541-0444 or (800)765-4224, follow the voice prompts to be directed as appropriate. The phone prompts will allow you to request additional ID cards and obtain other information through your touch tone phone. If you would like to speak to a representative it will direct you to the appropriate customer service representative.

How can I be sure my dental provider knows what services are covered?

The new enrollee packet you received included several documents, one of which is your Certificate of Coverage. The certificate's cover page would be identified with the carrier's name across the top and the applicant's identifying information just below. The certificate will provide definitions applicable to the policy as well as explain the coverage provisions. Also included within the certificate is a Coverage Schedule. The Coverage Schedule will indicate at what benefit level covered services will be paid, what services have a waiting period, whether a deductible will be applied and what services are not covered by your plan.

You may want to provide your dentist with a copy of the Coverage Schedule to know, when discussing treatment plans, what services are covered under the plan.

For treatment or services exceeding $300 we request that the dentist submit a pre-treatment estimate prior to such treatment or services. You will be notified in writing of the services allowed under the policy. Alternate procedures to the proposed plan may be suggested, based on professionally endorsed dental care standards.

Claims submitted for dental review must include copies of the applicable x-rays or dental charting to make a determination.

The written Predetermination of Benefits is valid for 90 days and is subject to the coverage terms listed.

Provide the dental office with the information on your ID card when scheduling an appointment and receiving treatment.

What does a dental provider need in order to submit a claim?

Meritain Health will accept any standard dental claim form or itemized billing statement that includes:
The patient identification (including full name, date of birth and address)
The applicant's name & Identification Number
Provider name, address and tax identification number
Date of service
Current ADA procedure code and fee charged

The claim can be mailed to:
Meritain Health
P.O. Box 27267
Hopkins, MN 55343-0738

What do I do if my family status changes?

If you are requesting termination of a dependent's coverage a written request signed and dated by the applicant should be submitted to Meritain Health. If termination of a dependent will change the type of coverage, for example from family to applicant and spouse, the change will be effective the first of the month following receipt by Meritain Health of such notification.

If you are adding dependents they must be added within 31 days of a qualifying event, such as birth, adoption or marriage by submitting a new application. Applications received later than 31 days of a qualifying event will result in the dependent's coverage being deferred to the applicant's next policy anniversary date.

OUR BUSINESS IS TO SERVE YOU! For Administrative question please contact Meritain Health at:

Administered by:

Mailing Address: Meritain Health
400 Highway 169 South Suite 800
Minneapolis, MN 55426

Phone Number: (952) 541-0444; (800) 765-4224
Fax: Number: (952) 593-3711 (Changes, terms and Adds)
Email: FINewbusiness@meritain.com

"Employer Questions regarding Spirit Dental Plans"

How do I enroll my employees on this dental plan? Employees should complete a Spirit Dental enrollment form and mail or fax to the address or phone number listed below.

How do I make changes for a currently enrolled member? Complete a Meritain Health change form (supplied in your Administrative Folder) and mail, email or fax to Meritain Health. **Please do not cross off names on the billing statement.**

- ❑ To speed up the processing of terminations, fax Meritain Health the member's name, SSN# and the last day of coverage.
- ❑ Check with Meritain Health before adding dependents to existing coverage. Some plans have eligibility requirements.

How can I make the enrollment process run smoothly? Double check enrollment forms before sending to Meritain Health. Please make sure your employees have provided all of the requested information.

- ❑ Complete information will ensure the timely enrollment of your members and prompt claim payments.
- ❑ A missing employee SS number may prevent Meritain Health from adding the person to their system. In addition, the group name employment date, birthdate, dependent names and birthdates are also needed to complete the enrollment process.
- ❑ Dependent eligibility for Full Time Students (FTS) varies by state, please check with your agent if you are unsure of your states requirement. For states with FTS provisions, children age 19 and older will not be added to the plan until Meritain Health has received documentation noting the current semester . Acceptable verifications are tuition receipt, class schedule, or a letter from the educational institution.
- ❑ Prior credit for waiting periods can be applied to employees who have continuously been covered under your groups prior dental plan. You must submit a copy of your prior carrier's billing statement with the group application, including the original effective date of each employee's prior coverage and the type of coverage they had with the prior plan (for example single, employee plus spouse or family). Prior credit is not available if there has been a break in coverage or for any employees that were not previously covered by your group's prior plan.

Enrollment changes are processed within 2 business days of receipt.

- ❑ Change requests received after bills have been produced for the month will be reflected on the next month's bill.

How do I get ID cards or certificates? These are automatically prepared for new members.

- ❑ To request a replacement, call Meritain Health and follow the voice prompts to the Customer Service Department.

How do I get supplies? Your agent can provide any additional applications.

When will I receive the monthly premium billing? Bills are mailed between the 7th &15th of each month.

- ❑ If you do not receive a monthly bill, please notify Meritain Health's Customer Service department.

When is the payment due? The payment is due by the first of the month. Drafting of payment can be setup through a checking, savings or credit card account. If paying by check please include a copy of your bill with the payment.

- ❑ It is recommended that you pay the amount on the statement. Adjustments will be made on the following month's statement for any additions or terminations you have made each month. This is to avoid the group to be under paid, which could cause delayed claim payments or termination of the policy.

Please remember – Meritain Health is the Administrator of the plan. Do not contact Security Life Insurance Company.
All questions, claims, phone calls, enrollment and changes forms go to Meritain Health.
We appreciate your assistance and value you as a policyholder.