

**DentAssure Dental/Vision
Plans
Employer Application**

For Company Use Only

ER #		Agent #		Eff. Date	
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PLEASE PRINT IN SPACE PROVIDED

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Indemnity
GH-1112-38220 | <input type="checkbox"/> PPO Scheduled
GH-1112-38222 | <input type="checkbox"/> PPO UCR
GH-1112-38223 | <input type="checkbox"/> Vision
GH-1157-38221 |
|---|---|---|--|

GROUP INFORMATION

Legal name of Employer Applicant (Policyholder): _____

Nature of Business:	Federal Tax ID No.:	SIC Code:	
Mailing Address:	City:	State:	Zip Code:
Street Address (if different from above):	City:	State:	Zip Code:
Name and Title of Employer Plan Administrator/Human Resources Contact:	Phone Number: () ()	Fax Number: () ()	
e-mail Address:	Proposed Effective Date of Insurance:		

Advance payment of \$ _____ is being submitted herewith to be applied by the Company to premiums for insurance when and if issued.

ELIGIBILITY

The term "eligible employees", when used below, means actively working full-time (at least 30 hours per week) employees who have completed their waiting period.

- | | | |
|---|-------|---------------------------------|
| (A) Total No. of all employees (full-time, part-time, seasonal, etc.) | _____ | Please explain any differences. |
| (B) Total No. of eligible employees | _____ | _____ |
| (C) Total No. of eligible employees enrolled | _____ | _____ |
| (D) Total No. of eligible employees with dependents | _____ | _____ |
| (E) Total No. of eligible employees who enrolled dependents | _____ | _____ |
| (F) Total No. of eligible employees in their waiting period | _____ | _____ |
| (G) Are there any classes of full-time employees excluded from coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the class. | _____ | |
| (H) A copy of your Employee Quarterly Wage Report (if applicable) must accompany this application. | | |

Waiting Periods:
Number of months for employees hired after the requested effective date is: _____
Coverage will be effective the first of the month following the stated waiting period.

Employer Contribution Level
 100% Employer Paid OR _____ % Employer Paid for both employee and dependent coverage.
OR the following Employer Contribution Level:
1. For Employees: _____ % OR \$ _____ 2. For Dependents: _____ % OR \$ _____

PRIOR CARRIER INFORMATION

If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, give the carrier, the type of coverage and the date the insurance was or is to be discontinued.

Carrier Name	Type of Coverage	Termination Date
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For Prior Coverage Credit to be considered, this application must be accompanied by a current month's billing from the current carrier, a copy of an in-force certificate and benefit schedule as well as proof of the effective date for each Insured Individual (and dependents, if insured).

Underwritten by:
Security Life Insurance Company of America
Minnetonka, MN 55343

Administered by:
Integrity Administrators, Inc.
P.O. Box 13128, Sacramento, CA 95813-3128
Phone: (800) 562-9383 Fax (916) 921-3383

- PLEASE COMPLETE OTHER SIDE -

