



## The First Rehabilitation Life Insurance Company of America

600 Northern Boulevard, Great Neck, New York 11021-5202  
(516) 829-8100(800) 365-4999 Fax: (516) 829-8211  
www.firstrehab.com

### MASTER APPLICATION

This application is made to The First Rehabilitation Life Insurance Company of America for a policy of group dental expense insurance. The application will become part of the policy. The policy will be issued based on the information in this application. (Please print or type your answers. Please answer all of the questions.)

- 1) Company Name (Policyholder): \_\_\_\_\_  
Correspondent: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone Number: (\_\_\_\_) \_\_\_\_\_
- 2) List the names and addresses of all subsidiaries or affiliated companies whose employees will be covered by the policy.  
\_\_\_\_\_  
\_\_\_\_\_
- 3) Nature of business: \_\_\_\_\_  
(if more space is needed, attach an extra sheet of paper.)
- 4) Total number of full-time employees: \_\_\_\_\_. (A full-time employee is one who works a minimum of 30 hours per week on a permanent, full-time basis at the employer's usual place of business or at a location specified by the employer.)
- 5) Total number of eligible employees: \_\_\_\_\_. Full-time employees who have completed one month of employment, and their eligible dependents, may be covered immediately by this policy. Other full-time employees and their eligible dependents shall be eligible on the premium due date after completion of the following waiting period: \_\_\_\_\_
- 6) Total number of employees to be insured: \_\_\_\_\_
- 7) Class(es) of employees eligible (describe): \_\_\_\_\_  
\_\_\_\_\_
- 8) Class(es) of employees ineligible (describe): \_\_\_\_\_  
\_\_\_\_\_
- 9) Has the group ever had dental coverage? \_\_\_\_\_. If yes, name of carrier? \_\_\_\_\_  
Reason for termination? \_\_\_\_\_
- 10) Has the group ever had coverage with First Rehab? \_\_\_\_\_  
If yes, what type? \_\_\_\_\_ For how long? \_\_\_\_\_  
Reason for termination? \_\_\_\_\_

- 11) This program is on a (check one) contributory \_\_\_\_; or non-contributory \_\_\_\_ basis. (If this is a contributory program, there must always be at least 75% participation.)  
Please check: \_\_\_\_ employee-only coverage; or \_\_\_\_ employee and dependent coverage.
- 12) The premium is paid monthly on the first day of each month. The premium of \$\_\_\_\_\_ for the first month must be sent with this application.
- 13) This policy is effective on \_\_\_\_\_ at 12:01 A.M. local time at the place at which this policy is delivered.
- 14) Schedule of benefits: Please check applicable item(s) in each section.
- I. Deductible: \_\_\_\_\_ \$25; \_\_\_\_\_ \$50; \_\_\_\_\_ \$75; \_\_\_\_\_ \$100
- II. Deductible: \_\_ waived for preventative services; \_\_ not waived for preventative services.
- III. Family deductible: \_\_\_\_\_ 2 per family; \_\_\_\_\_ 3 per family
- IV. Calendar year maximum benefit per person (for orthodontia see Item V below):  
\_\_\_\_\_ \$500; \_\_\_\_\_ \$750; \_\_\_\_\_ \$1,000; \_\_\_\_\_ \$1,500; \_\_\_\_\_ \$2,000
- V. Lifetime orthodontia maximum per person (Mandatory 50% Co-Insurance)  
\_\_\_\_\_ None; \_\_\_\_\_ \$500; \_\_\_\_\_ \$750; \_\_\_\_\_ \$1,000
- VI. Coinsurance (fill in %): \_\_\_\_\_ Preventative; \_\_\_\_\_ Basic; \_\_\_\_\_ Major
- 15) Monthly rates will be \_\_\_\_\_ per single employee; \_\_\_\_\_ per employee and spouse; \_\_\_\_\_ per employee and child(ren); and \_\_\_\_\_ per family unit (including the employee).
- 16) Network option: \_\_\_\_\_ Yes \_\_\_\_\_ No

No one except the President, a Vice President, the Secretary, or the Treasurer of The First Rehabilitation Life Insurance Company of America may make or modify any contract on behalf of The First Rehabilitation Life Insurance Company of America. No waiver is valid unless it is in writing and signed by one of these officers.

All statements made by the Applicant are true and correct to the best of the Applicants knowledge and belief.

***NOTICE:*** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Dated \_\_\_\_\_ Signature of Employer \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Dated \_\_\_\_\_ Signature of Agent \_\_\_\_\_

Agent's Address \_\_\_\_\_

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THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA