MASTER APPLICATION FOR EMPLOYEE BENEFITS

The United States Life Insurance Company in the City of New York
Member American General Financial Group
(Called United States Life)

United States Life's group underwriting rules will be used to determine whether the applicant, if accepted, will participate in a Multiple Employer Trust, or will be issued a group policy.

Important Notice

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 a fraudulent insurance act, which is a crime. (This notice does not apply in Virginia).

IN NY: The above statement does not apply to life coverage, but only to accident and health coverage. Such a crime 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.

Applicant Data

1. Full Name of Applicant (Company): ______________________________
2. Street Address: ______________________________
   City: ______________ State: ________ Zip: ________ Telephone: (____) ______________
   Mailing Address (if different) ______________________________ Fax: (____) ______________
   City: ______________ State: ________ Zip: ________
   E-Mail Address: ______________________________ SIC Code: ______________
3. Applicant is a: ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Union
   ☐ Other (Explain): ______________________________
4. Nature of Business: ______________________________
5. Are the employees of any affiliated or subsidiary companies or any other locations to be covered? ☐ Yes ☐ No
   If yes, give details below. If more space is needed, attach a separate sheet.

Name of Company	*Nature of Business*	*Full Address*	*# of Full-Time Employees*

6. Have you ever applied for, or been insured for, group insurance with United States Life? ☐ Yes ☐ No
   If yes, give details: Group Policy Number(s) ______________________________
   Date Insurance Ended/Declined ______________ Effective Date (if still insured) ______________
7. Please complete the information below for those coverages being replaced:

Current Coverage Employer		*Voluntary*		*Replacing with USL Plan?**	*Prior Plan Name & Effective Date*	*Proposed Termination Date*
Life**	☐	Life**	☐	☐ Yes ☐ No		
Dental	☐	Dental	☐	☐ Yes ☐ No		
STD	☐	STD	☐	☐ Yes ☐ No		
LTD	☐	LTD	☐	☐ Yes ☐ No		

* **Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).**

** Are there other Group Life Insurance plans in force which you are not replacing or currently applying for with another carrier? ☐ Yes ☐ No If yes, please indicate the highest benefit amount of each plan.

____

____

Will any coverages selected be part of a Flexible Benefit Program under section 125? ☐ Yes ☐ No
If Yes, please list coverages below and the percentage of the employee's contribution that is paid with pre-tax dollars.

☐ Life and AD&D ________% ☐ Dental/Vision ________% ☐ Disability ________%

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the United States Life plan may not take effect until the day after the existing insurance is terminated.

For Home Office Use Only	Group Number:	Division Number: ______________

Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least 30 hours (20 hours for Voluntary Life only) per week, or _____ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.

8. Do you want to exclude any classes of full-time employees from coverage? ☐ Yes ☐ No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** ____
____ Total # of excluded employees ____________

Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

9. Waiting Period: Present Employees ☐ ______________months OR ☐ First of the month following ______________months*

Future Employees ☐ ______________months OR ☐ First of the month following ______________months*

*Only option available for Voluntary Coverages. Available on Group coverages with the 1st of the month effective date only.

10. a. Number of Full-Time Employees (Include employees not to be covered and those being continued) .... ____________

b. Number of Full-Time Employees **waiving all coverages** .... ____________

11. Do you employ 20 or more employees? (Include part-time, union, etc.) ☐ Yes ☐ No

Contribution Data – Not applicable to Voluntary Coverages

12. Will the employees be required to contribute toward the cost of the insurance? ☐ Yes ☐ No
If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.

Coverage	*Life/AD&D*	*Dep Life*	*EE Dental**	*Dep Dental**	*EE Vision**	*Dep Vision**	*STD*	*LTD*	*Integrated DI*
Employer %									

****The employer must contribute a minimum of 35% of the total dental and vision premiums.***

13. Premiums will be paid: ☐ Annually ☐ Semi-annually ☐ Quarterly ☐ Monthly ☐ EFT

Employee/Dependent Data

14. Are there any employees who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? ☐ **Yes** ☐ **No** If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. **NOTE: This question does not need to be answered for Life and AD&D groups with more than 50 employees insured, Dental coverages, or for Disability coverages with ten (10) or more employees insured.**

Name of Employee	*Date Disability Began*	*Current Amount of Group Life Insurance In Force*	*Describe Nature of Injury/Sickness*	*Date Return To Full-Time Work*

Requested Effective Date

I request that the coverage(s) chosen take effect on:

☐ the date the application is approved in writing by United States Life; or

☐ ________________ If the application is approved in writing by United States Life, this will be the Effective Date, which may not be changed.

For Employer Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included. For Voluntary Plans, the effective date must be the first of the month.

Applicant's Declaration

1. I verify that all employees applying for coverage listed on the census form are actively at work and working at least 30 hours per week, unless another minimum work requirement was authorized by The United States Life Insurance Company, and all employees meet the eligibility requirements as listed on the application.
2. I verify that the United States Life Insurance Company's benefit plan(s) have been offered to all employees. Completed waivers are attached for those employees and dependents electing not to participate in the plan(s). Note: Changes in the Census data, may affect previously quoted rates.
3. To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
4. The agent(s) appointed for this application is (are): ____.
5. I understand that this application may be an application to participate in a Multiple Employer Trust, as determined by the underwriting rules of United States Life. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund. A copy of the Trust Agreement will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Agreement.
6. I understand and agree that:
   - no agent may change or waive any of the provisions of this application or of any plan of insurance;
   - any change or waiver may be made only by an officer of United States Life; and
   - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
   - If the insurance contract compromises a part of an employee benefit plan, the United States Life Insurance Company is granted sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The United States Life Insurance Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.

DATE — _PRINT NAME OF OFFICER, PARTNER, PROPRIETOR_

WITNESS — _SIGNATURE OF OFFICER, PARTNER, OR PROPRIETOR_

Note: *If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.*

Producing Agent's Declaration

Please Print — PRODUCING AGENT

Producer #	**Tax ID # / SS #**	**% Commissions split with other agents**
Name ***As Licensed***		**License #**
Mailing Address		
City/State/Zip		
Phone	Fax	E-Mail
Signature	***Date***	***City and State Where Signed***

Please Print — GENERAL AGENT

General Agent #	**Name**	**Tax ID # / SS #**
Phone	Fax	E-Mail

HOME OFFICE USE ONLY

Policy No.	**Premium Deposit $**	**Underwriter**
Mode	**Coverages**	
Group Contact	**Producer**	**GA**

Census Information *(This form may be photocopied if additional supply is needed)* – Not applicable for Voluntary Coverages or any group applying for Dental and Vision

For H.O. Use Only	Employee's Soc. Security#	Name (Last, FIrst, MI)	Sex M/F	City/State of Residence	Current Salary***	Date of Birth			Occupation/ Title*	Date of Hire			Marital Status**	# of Dependents	Coverage Election E - Employee S - Spouse, C - Child	Coverage Selected			
Class/Div.						M	D	Y		M	D	Y				Life	LTD	STD	INT. DIS
1.	- -																		
2.	- -																		
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17.	- -																		
18.	- -																		
19.	- -																		
20.	- -																		

**Please indicate state or federal coverage continuation here. Mark column with "C" along with date continuation began.*
***Marital Status Codes: S-Single, M-Married, W-Widowed, D-Divorced*
****Please state if salary is per hour, per week, per month or per year.*

For H.O. only:
Group Number: ______________________

For H.O. use only: Group Number: ______________
Class __________________ Division __________

DEPENDENTS INFORMATION AND BENEFICIARY DESIGNATION FORM

To be completed by each employee

The United States Life Insurance Company in the City of New York
Member American General Financial Group
(Called United States Life)

This form may be used only in conjunction with a Group Enrollment Census form for initial enrollment. This form is not an employee application and should not be used for the addition of new employees.

Employee Information

Employee's Name: ____
LAST FIRST MI

Name of Employer: ____

Group #: ______________________ Social Security # ______________________

Dependent Information for Life Coverage

To insure your dependents, please complete the following: (Employee is the beneficiary for all insured dependents)

Spouse's Name ______________________________ Birthdate _______/ _____/ _______
LAST FIRST MI

Social Security No. ______________________ ☐ Male ☐ Female

Applicant's Signature: ______________________ Date: ______________________

Beneficiary Designation

If applying for Life Coverage, enter the Beneficiary information.

Beneficiary Name: ______________________ Relationship ______________________
LAST FIRST MI

Contingent Beneficiary: ______________________ Relationship ______________________
LAST FIRST MI

Applicant's Signature: ______________________ Date: ______________________

REFUSAL OF COVERAGE

Employee Information (Please Print)

Employee's Name: ____
LAST FIRST MI

Name of Employer: ____

Please complete, and sign this form if you are refusing coverage for any of the following insurance products.

Please check the appropriate box(es).

☐ Life ☐ Dependent Life ☐ Long Term Disability ☐ Short Term Disability ☐ Integrated Disability

NOTE: Enrollment/Refusal Form #00302101-1113 is required for each employee for Dental and Vision coverages.

Please Read and Sign:

I, the undersigned, hereby affirm that I have reviewed the insurance plan(s) from The United States Life Insurance Company being offered by my employer. With my signature, I certify that I have decided to refuse coverage. I understand that if I should later decide to enroll, I will be considered a late enrollee and may be subject to Evidence of Insurability and/or reduced benefits.

Signature: ____________________________________ Date: ______________________

This form must be photocopied for each employee to complete.

Life/AD&D – Ultimate Advantage and Quality Series

Application must be filled out with Master Application 00305101-1183

Group Name ____

- Waiver of Premium included
- Reduction Formula: Life Insurance and AD&D insurance reduce by 50% at age 70.
- For Ultimate Advantage, AD&D insurance terminates at age 70.
- BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay or other special compensation such as commissions.

INSURANCE SCHEDULE

- Life and AD&D insurance will be written in equal amounts, subject to the AD&D maximum of $500,000.

Class of Employees List by salary, job title, union membership or other employment conditions.	*Life / AD&D Amounts NOT Subject to EOI*	*Life / AD&D Amounts Subject to EOI*	*Total Amount Requested Per Life* *Life* *AD&D*
1.			
2.			
3.			
4.			
5.			

CHANGE IN AMOUNT OF INSURANCE: A change in the amount of Life and AD&D insurance will take effect on:

☐ the date of change ☐ other ____

BENEFIT OPTIONS

SEAT BELT ☐ Yes ☐ No

ACCELERATED DEATH ☐ Yes ☐ No (must have minimum $20,000 basic life volume)

NOTE: INCLUDED WITH ULTIMATE ADVANTAGE LIFE. NOT AVAILABLE IN ALL STATES FOR QUALITY SERIES LIFE PLANS.

DEPENDENT LIFE INSURANCE ☐ Yes ☐ No

Amounts: Spouse/Child ☐ $10,000/2,000 ☐ $5,000/1,000

ADDITIONAL OPTIONS ***(For Quality Series Only!)***

- Available to groups of 10+ lives and subject to PRIOR Home Office approval
- Not available for Ultimate Advantage Series

Check all that apply

☐ AD&D only

☐ Life only ☐ without waiver of premium

☐ Dependent Life Insurance Selections:

☐ legal spouse of employee ☐ children ages 15 days to ______ years, ______ if student

Amount: Spouse $______________ Children $______________ (Maximum: spouse $10,000/Children $5,000)

☐ Reduction Formula: Please specify if different from above (ie. 50% at age 70)

Life ____

AD&D ____

☐ Special Requests: ____

For H.O. use only: Group Number: ______________
Division Number: ______________________________

Disability

Must be filled out with Master Application 00305101-1183

Group Name ____

- Is the business run from the home? ☐ Yes ☐ No How long has business been in existence? ___________ years
- Are there any employees who do not participate in Social Security or Worker's Compensation? ☐ Yes ☐ No

If yes, explain ____

LONG TERM DISABILITY BENEFITS

	The Ultimate Advantage Series 2-24 Lives	Quality Series 10 or more lives
Elimination Period	☐ 90 or 180 days	_______ days
Benefit per Month of Disability	60% of Basic Monthly Pay, up to a maximum of $_________ ($1,000 to $6,000 in $1,000 increments)	_______% of Basic Monthly Pay, up to a maximum of $_____________
Integration	☒ Family	☐ Family ☐ Primary ☐ 70% All Sources
Own Occupation Period	☒ 2 Years	☐ 2 Years ☐ 3 Years ☐ 5 Years ☐ Extensive (to age 65) ☐ Other_______________
Minimum Benefit of gross monthly benefit	The greater of $50 or 10%	$__________
Maternity as any other sickness	☒ Yes	☐ Yes ☐ No ☐ Self funded
Pre-Existing Conditions Limit	12/24 (or as mandated by state)	☐ 12/6/24 ☐ 3/6/12 ☐ Other
Survivor Benefit	3 Months	☐ 3 Months ☐ Other
Mental, Nervous, Drug & Alcohol Limitation	☒ 12 Months	☐ 24 Months ☐ Other
Benefit Duration	☒ Age 65 RBD	☐ Age 65 RBD ☐ 5 Year RBD ☐ NSSRA ☐ 2 year RBD
Partial Definition	☒ Partial	☐ Partial ☐ Progressive Partial ☐ Other
Conversion Option	Not available	☐ Yes ☐ No
COLA	Not available	☐ Yes ☐ No __________% _______Adjustments

SHORT TERM DISABILITY BENEFITS

	The Ultimate Advantage Series 2-24 Lives	Quality Series 10 or more lives
Benefit per Week of Disability	☐ 60% of Basic Weekly Pay, $________ (not to exceed $750) ☐ Flat Amount $____________ Not to exceed 60% of Basic Weekly Pay	☐ ____% of Basic Weekly Pay, not to exceed $_______ (not to exceed $1,000) ☐ Flat Amount $_______________ Not to exceed 60% of Basic Weekly Pay
Benefit Begins	1st day for accident 8th day for sickness	_____ day for accident _____ day for sickness
Include Partial Disability Benefits	Not available	☐ Yes ☐ No
Elimination Period Waived If Hospitalized	Not available	☐ Yes ☐ No
Maximum Weeks per Disability	☐ 13 ☐ 26 ☐ 52 Weeks	_____ Weeks
Maternity as any other sickness	☐ Yes ☐ No (Available for 2-14 lives only if required by law)	☐ Yes ☐ No (Available for 10-14 lives only if required by law)

INTEGRATED DISABILITY BENEFITS

The Ultimate Advantage Series 2-24 Lives

Benefits Begin (accident/sickness)	☐ 8/8 ☐ 15/15 ☐ 30/30 Days
Integration	☒ Family
Benefit per Month of Disability	60% of Basic Monthly Pay up to a maximum of $___________ ($1000-$6000 in $1000 increments)
Own Occupation Period	☒ 2 Years
Maternity as any other sickness	☒ Yes
Minimum Benefit	The greater of $50 or 10% of gross monthly benefit
Mental, Nervous, Drug & Alcohol Limitation	☒ 12 Months
Pre-Existing Conditions Limit	12/24 (or as mandated by state
Survivor Benefit	3 Months
Benefit Duration	☒ Age 65 RBD
Partial Definition	☒ Partial

☐ Special Requests ____

Voluntary Coverages

Must be filled out with Master Application 00305101-1183A

For H.O. use only: Group Number: ______________
Division Number: ______________

1. Correspondent's full name and address: (If different than indicated on page 1) ______________________________

____

NOTE: Person named above is required to communicate individual coverage status to the employee.

2. Number of payroll deductions per year ______________
3. Enrollment/Solicitation dates ______________ to ______________
4. Individual Age bracket changes and increase in amounts of insurance will take effect:
   ☐ Plan Anniversary ☐ First of the month following the change

LIFE INSURANCE: ☐ Yes ☐ No

BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay or other special compensation such as commissions.

2-199 LIVES

A. Premium rate schedule:
   ☐ Unismoke **OR** ☐ Smoker/Non-smoker
B. Waiver of premium: standard
C. Requested benefit schedule: standard
   Employee: $10,000 to $300,000 available in $10,000 increments, not to exceed 5X the employee's basic annual salary.
   Spouse: $10,000 to $300,000, available in $10,000 increments, not to exceed 5X the employee's basic annual salary.
   Children: $5,000

200+ LIVES

A. Premium rate schedule:
   ☐ Unismoke **OR** ☐ Smoker/Non-smoker
B. Waiver of premium (if proposed) ☐ Yes ☐ No
C. Requested benefit schedule:
   Employee: ______________
   Spouse: ______________
   Children: ______________
   Please advise if any of the above are excluded.

Please note: For groups domiciled in Florida and Texas, spouse amount limited to 50% of employee's amount. In New York spouse limited to employee's amount.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D): ☐ Yes ☐ No

BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay or other special compensation such as commissions.

2-199 LIVES

A. Requested benefit schedule: standard
   Employee: $10,000 to $300,000, available in $10,000 increments, not to exceed 5X the employee's basic annual salary.
   Spouse: $10,000 to $300,000, available in $10,000 increments, not to exceed 5X the employee's basic annual salary.

200+ LIVES

A. Requested benefit schedule:
   Employee: ______________
   Spouse: ______________

Please note: Dependent children are not eligible for AD&D. For groups domiciled in Florida and Texas, spouse amount limited to 50% of employee's amount. New York spouse limited to employee's amount.

LONG-TERM DISABILITY: ☐ Yes ☐ No

2-199 LIVES

A. Rate chart used: ______________
B. Benefit percentage: $100 units to a maximum of
   ☐ 50% ☐ 60%
C. Benefit maximum: $6,000
D. Benefit duration: ☐ Ages 65 RBD
   ☐ 5 year RBD ☐ Other: ______________
E. Elimination period: ☐ 30 Days* ☐ 60 Days*
   ☐ 90 Days ☐ 180 Days

200+ LIVES

A. Attach copy of proposal
B. Benefit percentage: $100 units to a maximum of
   ☐ 50% ☐ 60% ☐ Other
C. Benefit maximum: $______________
D. Benefit duration: ☐ Ages 65 RBD
   ☐ 5 year RBD ☐ Other: ______________
E. Elimination period: ☐ 30 Days* ☐ 60 Days*
   ☐ 90 Days ☐ 180 Days ☐ Other: __________

*30 and 60 day elimination periods are not available with age 65 RBD plans.

Please note: Spouses and dependent children are not eligible for LTD.

SHORT-TERM DISABILITY: ☐ Yes ☐ No

2-199 LIVES

A. Female percentage rate chart used: ______________
   Note: Full census required
B. Benefit percentage: $10 units to a maximum of
   ☐ 50% ☐ 60% **OR** Flat ☐ 50% ☐ 60%
C. Benefit maximum: ☐ $300 [2–9 eligible] ☐ $500 [10+ eligible]
D. Benefit duration: ☐ 13 Weeks ☐ 26 Weeks
E. Elimination period: (for accident and/or sickness)
   ☐ 15 Days ☐ 30 Days
F. Pre-existing conditions limitation
   ☐ 12/12 ☐ Other ______________

200+ LIVES

A. Attach copy of proposal
B. Benefit percentage: $10 units to a maximum of
   ☐ 50% ☐ 60% **OR** Flat ☐ 50% ☐ 60%
C. Benefit maximum: $______________
D. Benefit duration: ☐ 13 Weeks ☐ 26 Weeks ☐ Other
E. Elimination period: (for accident and/or sickness)
   ☐ 15 Days ☐ 30 Days ☐ Other ______________
F. Pre-existing conditions limitation
   ☐ 12/12 ☐ Other ______________

Please note: Spouses and dependent children are not eligible for STD.

(Turn Over)

Voluntary Coverages (cont'd)

DENTAL: ☐ Yes ☐ No

❏ Discount Plan ☐ UHP **OR** ☐ Careington Network

OR

❏ Indemnity Plan [minimum 10 eligible employees with 5 enrolled]

Annual Deductible ☐ $25 **OR** ☐ $50

Annual Maximum (Non-Orthodontic) benefit: $1000 per insured person

Coinsurance

	Preventative **Year 1/Thereafter**	**Basic I** **Yr. 1/Thereafter**	**Basic II** **Yr. 1/Yr. 2/Thereafter**	**Major** **Yr. 1/Yr. 2/Thereafter**
❏ Plan A	100%	50%/80%	25%/50%/80%	0%/25%/50%
❏ Plan B	80%/100%	50%/80%	0%/50%/80%	0%/25%/50%

❏ Orthodontia ☐ Yes: Adult/Child ☐ Yes: Child only ☐ No

- No deductible applies to Orthodontia
- Orthodontia benefit begins on Year 3
- Orthodontia benefit is 50% coinsurance not to exceed lifetime maximum of $1000 per insured person.

For H.O. use only: Group Number: ___________
Division Number: ___________

Dental and Vision

Must be filled out with Master Application 00305101-1183
Enrollment Form #302101-1113 is required for all Dental and Vision Plans

Group Name ______________________ ☐ Employee Only ☐ Employee and Dependents

Reasonable and Customary Plans:

☐ Ultimate Advantage Dental *(available 2-24 lives)*

	Deductible	*Coinsurance*	*Deductible Waived for Preventive*	*Annual Maximum*
☐ Plan 1	$50	100%/80%/50%	☐ Yes ☐ No	☐ $1,000 ☐ $1,500
☐ Plan 2	$100	100%/80%/50%	No	☐ $1,000 ☐ $1,500
☐ Plan 3	$50	100%/80%/0%	☐ Yes ☐ No	$1,000

☐ UltraDent Dental *(available 10+ lives)*

Annual Deductible: $__________ Family Limit: 3X

Coinsurance: Preventive ________% Basic ________% Major ________%

Annual Maximum: ☐ $1000 ☐ $1500 or ☐ $2000

Deductible waived for preventive: ☐ Yes ☐ No

All dental waiting periods waived ☐ Yes ☐ No

Orthodontia: ☐ Yes; Lifetime Deductible: $0 ☐ No
50% Coinsurance
Lifetime Maximum: ☐ $1000 ☐ Other ____________

Adult (Age 19+) Orthodontia: ☐ Yes ☐ No

NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

Point-of-Service PPO Plans:

☐ Trudent MAC (Maximum Allowable Charge) ☐ 2-9 lives ☐ 10 or more lives

Annual Deductible: $____________

Coinsurance:		IN	OUT
	Preventive	____________ /	100%
	Basic	____________ /	80%
	Major	____________ /	50%

Annual Maximum: $ ____________ / ____________ $
☐ Waiting periods waived

Orthodontia: ☐ Yes, Lifetime Deductible: $0 ☐ No
Coinsurance: ________%
Lifetime Maximum: ☐ $1000 ☐ Other ________

Adult Orthodontia: ☐ Yes ☐ No
(Age 19+)

Networks Available:
(Check network applicable to your area)

- ☐ Delta Dental of Colorado
- ☐ Delta Dental of New Jersey
- ☐ Delta Dental of Connecticut
- ☐ First Dental Health (CA)
- ☐ Delta Dental of Illinois
- ☐ Signature PPN (Mass)
- ☐ Signature PPN (PA)
- ☐ Signature PPN (FL)
- ☐ Healthplex (NY)
- ☐ Careington International (Texas)

NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

☐ Trudent R & C (Reasonable & Customary) – *available 10 or more lives*

Annual Deductible: $____________

Coinsurance:		IN	OUT
	Preventive	____________ /	____________
	Basic	____________ /	____________
	Major	____________ /	____________

Annual Maximum: $____________ / $____________
☐ Waiting periods waived

Orthodontia: ☐ Yes, Lifetime Deductible: $0 ☐ No
Coinsurance: ________%
Lifetime Maximum: ☐ $1000 ☐ Other ________

Adult Orthodontia: ☐ Yes ☐ No
(Age 19+)

Networks Available:
(Check network applicable to your area)

- ☐ Delta Dental of Colorado
- ☐ First Dental Health (CA)
- ☐ Delta Dental of Illinois
- ☐ Signature PPN (FL)
- ☐ Signature PPN (Mass)
- ☐ Signature PPN (PA)
- ☐ Healthplex (NY)

NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

Scheduled Plan:

☐ Reimbursement Dental Plan *(Available 5+ lives)*

Annual Deductible: ☐ $0 ☐ $25 ☐ $50 ☐ $100

Conversion Factor ($10-$20): $____________

Annual Maximum: ☐ $500 ☐ $750 ☐ $1000 ☐ $1500 *(10+ lives only)*

Preventive dentistry covered at 100% of Reasonable and Customary with deductible waived: ☐ Yes ☐ No

Orthodontia: ☐ Yes; Lifetime Deductible $50 ☐ No
50% Coinsurance
Lifetime Maximum: $1000

NOTE: Orthodontia is available only to groups of 10 or more lives and is paid at Reasonable and Customary.

Healthplex Programs (NY/NJ):

☐ Dual Option Dental *(Available 5+ lives in specific areas. Consult your agent for information.)*

Reimbursement/Healthplex Comprehensive Plan Benefits

Conversion Factor/Benefit level: ☐ $10 (Low) ☐ $14 (Medium) ☐ $18 (High)

Annual Reimbursement Deductible: $ ______________

Annual Reimbursement Maximum: $ ______________

Preventive Dentistry Covered at 100% with deductible waived (Reimbursement): ☐ Yes ☐ No

Orthodontia: ☐ Yes ☐ No
Reimbursement Lifetime Deductible: $50
Reimbursement Coinsurance: 50%
Reimbursement Lifetime Maximum: $1000

NOTE: Orthodontia is available only to groups of 10 or more lives. (Must be made available on both plans.)

☐ Healthplex Comprehensive Dental *(Available 1+ lives in specific areas. Consult your agent for information.)*

Option (circle one): ☐ High - $18 ☐ Medium- $14 or ☐ Low - $10 Orthodontia: ☐ Yes ☐ No

☐ Healthplex Comprehensive Voluntary - Dental *(Available 1+ lives in specific areas. Consult your agent for information.)*

*Employees may choose High, Medium, Low, or Economy Options on their individual enrollment forms.

Orthodontia: ☐ Yes ☐ No

Voluntary Plan:

☐ Voluntary Dental (Discount Dental Service Plan) - U.H.P. or Careington Network

DHMO Dual Option Programs (Nationwide):

☐ Informal Dual Option/ UltraDent Dental *(Available 10+ lives. UltraDent plan sold alongside another Company's prepaid plan.)*

☐ Plan I

$50 annual deductible - Coinsurance:

Preventive	100%
Basic	80%
Major	50%

Annual Maximum: ☐ $1000 ☐ $ 1500

☐ Plan II

$50 annual deductible - Coinsurance:

Preventive	80%
Basic	80%
Major	50%

Annual Maximum: ☐ $1000 ☐ $ 1500

Deductible waived for preventive: ☐ Yes ☐ No

☐ Informal Dual Option/Trudent Dental *(Available 10+ lives in specific areas. Consult your agent for information. Trudent Plan sold alongside another company's prepaid plan. MAC plans only.)*

Annual Deductible: $50

VISION INSURANCE (not available standalone < 100 lives)

	IN-NETWORK	OUT OF NETWORK
☐ **TruVision: Plan 1**		
Comprehensive Eye Exam:	No Copay	$35 Reimbursement
Exam Frequency:	Biennial	Biennial
Eyewear Allowance: Lenses/Frames or Contacts	20% Discount	Not Applicable
Eyewear Frequency:	Unlimited	Not Applicable
☐ **TruVision: Plan 2**		
Comprehensive Eye Exam:	$10 Copay	$25 Reimbursement
Exam Frequency:	Biennial	Biennial
Eyewear Allowance: Lenses/Frames or Contacts	$75 Total Allowance Plus 20% Discount On Materials Exceeding Allowance	$40 Reimbursement
Eyewear Frequency: Allowance:	Biennial	Biennial
Discount:	Unlimited	Not Applicable
☐ **TruVision: Plan 3**		
Comprehensive Eye Exam:	$10 Copay	$25 Reimbursement
Exam Frequency:	Biennial	Biennial
Eyewear Allowance: Lenses/Frames or Contacts	$125 Total Allowance Plus 20% Discount On Materials Exceeding Allowance	$75 Reimbursement
Eyewear Frequency: Allowance:	Biennial	Biennial
Discount:	Unlimited	Not Applicable

☐ **Special Requests** ____