United Concordia Insurance Company of New York

APPLICATION FOR GROUP DENTAL INSURANCE

APPLICANT'S LEGAL NAME AND ADDRESS:

Name

Address

NATURE OF BUSINESS:

INDUSTRY SIC CODE:

Is Applicant exempt from ERISA? Yes ☐ No ☐

For general correspondence, receipt of billings and certificates:

(If address is different than noted, place contact address on back)

Policymaker Name: ____________________

Title: ____________________

Phone: ____________ Fax: ____________

Email: ____________________

Group Administrator: ____________________

Phone: ____________ Fax: ____________

Email: ____________________

FFS PRODUCTS: FLEX: ☐ PREFERRED: ☐ SELECT: ☐ CHOICE: ☐ OTHER:

STANDARD OPTION: ________ ________ ________ ________ ________

	IN	OUT	STEP PLANS
Program Deductible: (Ind./Family)	$___/____	$___/____	$____/____

Deductible Max Period: Contract Year ☐ Calendar Year ☐ Lifetime ☐

Deductible Applied to all Services: Yes ☐ No ☐

If No, Services Exempt from Deductible: Class I ☐ Class II ☐ Class III ☐ Ortho ☐

	IN	OUT	STEP PLANS
Program Max: Yr ☐ Lifetime ☐	$_______	$_______	$_________
Ortho Max: Yr ☐ Lifetime ☐	$_______	$_______	$_________

Waiting Periods (Mos.): Class I _____ Class II _____ Class III _____ Ortho _____

FFS NETWORK REIMBURSEMENT:

Advantage ☐ Advantage Plus ☐

National FFS ☐ No Network ☐

Access ☐

Pricing -- In __________/Out ___________

DENTAL PREPAID PRODUCT:

PLUS/Third Column: ☐

Standard Plan_______________

Non-Standard Plan: attach detail

PREMIUM PAYMENT PERIOD:

Monthly ☐ Semi-Annually ☐

Quarterly ☐ Annually ☐

Premium must be paid in advance.
Checks payable to United Concordia.

GROUP EFFECTIVE DATE:

(1st of month) ____/____/____

PRIOR COVERAGE: Yes ☐ No ☐

Carrier ____________________________

RATES:

Certificate Holder: _____________

Certificate Holder & One Adult: _____________

Certificate Holder & One Child: _____________

Certificate Holder & Children: _____________

Certificate Holder & Family: _____________

PARTICIPATION SUMMARY:

______ # Eligible employees

______ # Enrolled

______ # Waived

______ # Spouse Opt-Outs

DEPENDENT COVERAGE INCLUDES:

Spouse ☐

Children ☐

Non-Students to Age _____

Students to Age _____

Domestic Partners ☐

RATE PERIOD: (MM/DD/YYYY)

From ____________________ 12:01 AM
(1st of month)

To ______________________12:00 AM
(Last day of month)

ELIGIBILITY WAITING PERIOD: New Certificate Holders are eligible for coverage on the _____ of the month following ______ days/mos in an eligible class, or other: ____
____.

THE APPLICANT REPRESENTS that: by signing this application, he/she agrees that the group dental insurance described above will become effective upon acceptance of this application by United Concordia (UC). Applicant further acknowledges that no coverage will be effective before the date determined by UC and only if the first Premium has been paid and underwriting bid qualifications are met. If this application is accepted, it becomes a part of the insurance contract between Applicant and UC. If this application is not accepted, any Premium advanced by the Applicant will be refunded.

Applicant warrants that all information on this application is true and complete, and acknowledges that coverage may be rescinded if there are material misstatements on this application. If errors or omissions in this application are discovered by UC, it is authorized to amend this application by noting the changes on this form, and the acceptance, evidenced by Premium payment, of any Policy issued on this application, so amended, shall constitute a ratification of any such changes or amendments. Upon policy renewal date, payment of the renewal premium will confirm acceptance of that renewal for the subsequent rate period.

No agent or broker has the right to accept this application or bind coverage. Any first premium or application submitted to UC or its sales personnel by a non-appointed producer must be accompanied by completed appointment paperwork or it will be returned to the non-appointed producer.

Any person who knowingly, and with intent to defraud any insurance company 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 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. (11 NYCRR Sec. 86.4 (2001) (Reg. 95) and General Counsel Opinion 2-3 2005 (#2)

Applicant: ______________________________ Dated at: ______________________________
(City) (State)

By: ______________________________ (Date) Producer: ____________________ SSN#: ____________

Title: ______________________________ Agency: ____________________ Tax ID: ____________

UC Producer ID#: Agency ______________ Producer ______________

United Concordia programs are underwritten by the following companies in the listed states:

United Concordia Dental Corporation of Alabama - AL
United Concordia Dental Plans, Inc. - MD, NJ
United Concordia Dental Plans of California, Inc. - CA
United Concordia Dental Plans of Delaware, Inc. - DE
United Concordia Dental Plans of Florida, Inc. - FL
United Concordia Dental Plans of Kentucky, Inc. - KY
United Concordia Dental Plans of the Midwest, Inc. - MI, MO, OH

United Concordia Dental Plans of Pennsylvania, Inc. - PA
United Concordia Dental Plans of Texas, Inc. - TX
United Concordia Insurance Company - AK, AR, AZ, CA, CO, CT, FL, GA, IA, ID, IN, KS LA, MA, MD, ME, MI, MN, MS, MT, NE, NV, NH, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY
United Concordia Life and Health Insurance Company - DE, DC, IL, KY, MD, MO, NC, NJ, PA
United Concordia Insurance Company of New York - NY

Products not available in any state where prohibited by law or where United Concordia does not have regulatory approval.