FORT DEARBORN LIFE
Insurance Company
Chicago, Illinois

Application & Change Form Group Voluntary Dental Benefits

Administrative Offices: Downers Grove, Illinois | Cleveland, Ohio | Dallas, Texas

I. APPLICANT

☐ New Application ☐ Change*

* To change your voluntary dental program, complete the items marked with a ✓ in Part I, check coverage in Part II, and sign in Part III.

✓Employer Name | ✓Contact (Name/Title)

Mailing Address (DO NOT USE P.O. BOX) Street City State Zip Code

✓Phone (______)_____________ Fax: (______)_____________
✓Email:
Nature of Business | SIC Code

✓Effective Date	First Anniversary	Number of Eligible Employees	Number Enrolled	✓Group Number

Waiting Period:

☐ None ☐ ____ Days ☐ First of month following _______days

Applicable to: ☐ All Employees ☐ Future Employees Only

Effective Date of Employee Participation:
The effective date of dental coverage is the first (1st) of the month following or coincidental to completion of any waiting period.

Does this coverage replace existing dental coverage? ☐ Yes ☐ No

Continuity of coverage for transfer insureds at takeover rates? ☐ Yes (PROVIDE COPY OF PRIOR PLAN & LAST LIST BILL) ☐ No

II. SCHEDULE OF BENEFITS (Plan or Plans selected shall be available to all eligible employees)

☐ **SCHEDULED BENEFIT PLAN** (Minimum Enrollment 2 Eligible Employees)
Plan pays a scheduled amount to service provider based on coverage level, procedure and region.

Coverage Level (select one) ☐ Gold (with orthodontics) ☐ Silver (without orthodontics) ☐ Bronze (without orthodontics) ☐ Gold and Bronze ☐ Silver and Bronze

Region ☐ Region 1 ☐ Region 2 ☐ Region 3 ☐ Region 4 ☐ Region 5

☐ **REASONABLE & CUSTOMARY (R&C) BENEFIT PLAN** (Minimum Enrollment 30 Eligible Employees)
R&C plan pays a percentage of the reasonable and customary charges to the service provider based on coverage level and procedure. The additional Bronze Plan is not R&C and does not include orthodontic coverage. Bronze Plan pays a *scheduled* amount to the service provider based on procedure and region.

Coverage Level (select one) ☐ Gold R&C (with orthodontics) ☐ Gold R&C and Bronze Scheduled Plan* ☐ Silver R&C (without orthodontics) ☐ Silver R&C and Bronze Scheduled Plan*

***Region** (required only if a Bronze Plan is elected) ☐ Region 1 ☐ Region 2 ☐ Region 3 ☐ Region 4 ☐ Region 5

III. GENERAL CONDITIONS It is understood and agreed that:

1. This application shall be made part of the Policy for which application is made.
2. All active employees who work at least______hours a week are eligible (minimum 20 hours).
3. Employee coverage is subject to the following conditions: Each employee must make written application to Fort Dearborn Life and sign an authorization for payroll deduction. Employees must be Actively At Work on their effective date of coverage, or coverage will be deferred until the date they return to Active Work. If an employee does not return to Active Work, he will not be covered.
4. Premiums are due and payable monthly on the first day of each month.
5. Except in LA, MD, ME, OR, SD, VT & WA, coverage is provided under a master group policy issued to DNoA Dental Plan Trust II.

Note: Certain coverages may be required to be offered in the state of issue. Such coverages, if any, are listed on an attached Supplement to Group Dental Insurance Application. Each coverage checked "Yes" is to be included. Each coverage checked "No" is not to be included.

The undersigned has read this entire application for dental insurance and agrees: (a) the information provided is accurate to the best of my knowledge; (b) this application and any other information I provide shall serve as the basis for the insurance to be issued; (c) I have a duty to notify the Company of any changes; and (d) I have relied on no oral or written representations that contradict item (3) above.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or statement of claim containing any materially false information and conceals information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties.

Signed at ____, this ___________ day of _____________________ Year:__________

______________________________ Authorized Signature

______________________________ Licensed Resident Agent (If required)

STATEMENT OF UNDERSTANDING

between

FORT DEARBORN LIFE INSURANCE COMPANY ("FDL")

and ____ ("the Employer")

The Employer hereby grants FDL the right to offer each of the Employer's eligible employees, as defined in the application, the opportunity to participate in the Voluntary Benefit Program. This authorization is based on the following reciprocal agreements:

1. An enrollment will be conducted of the Employer's eligible employees.
   An initial enrollment period will be held from ____________________________
   through ____________________________.

   Annual enrollment will be held ____________________________.
2. The Employer agrees to provide a letter endorsing the Voluntary Benefit Program.
3. The Employer agrees to distribute FDL enrollment materials to all eligible employees.
4. The Employer agrees to collect and communicate to FDL acceptance or declination of the plan by each eligible employee.
5. The Employer will administer payroll deductions for the employees and remit premiums monthly on the first of each month.
6. The Employer agrees to notify FDL as soon as possible when the voluntary or involuntary termination of a participating employee takes place.

Signed this __________day of___________________,Year__________

____
Authorized Signature / Employer

____
Authorized Signature / FDL

FORT DEARBORN LIFE
Insurance Company
Chicago, Illinois

Supplement to Application for Group Insurance

Administrative Offices: **Downers Grove, Illinois | Cleveland, Ohio | Dallas, Texas**

INSURANCE FOR TREATMENT OF TEMPOROMANDIBULAR JOINT DISORDERS
(OFFER MANDATED BY RCW 48.21.320)

This Supplement is to be attached to and form part of the Application.

RCW 48.21.320 requires that an offer be made to include insurance for temporomandibular joint disorders. The benefits for temporomandibular joint disorders are described briefly on the reverse of this form.

The option, if elected, may result in an additional premium.

If provided, the insurance, the conditions under which benefits will be payable, and other terms and conditions will be in accordance with the Policy issued and any amendments, riders, or endorsement thereto.

1. I acknowledge that:
   I have read and understand the description of the optional insurance for temporomandibular joint disorders as set out on the reverse of this form; and
   I have been informed of the cost (if any) of including this insurance in the Policy.

2. Is the insurance for temporomandibular joint disorders described in RCW 48.21.320 to be included in the Policy?

   __________ Yes   __________ No

Policyholder:____

By: ____

Title:____ Date: __________________

Insurance, if included, is provided for Dental Services relating to the treatment of temporomandibular joint disorders. Dental Services are those which are:

1. Reasonable and appropriate for the treatment of temporomandibular joint, under all the factual circumstances of the case; and

2. Effective for the control or elimination of one or more of the following caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food; and

3. Recognized as effective, according to the professional standards of good dental practice; and

4. Not experimental or primarily for cosmetic purposes.

The benefit is 50% of the Reasonable and Customary charges for covered treatment, to a maximum annual benefit of $1,000 per covered person, and to a maximum lifetime benefit of $5,000 per covered person.