

APPLICANT'S LEGAL NAME AND ADDRESS: Name _____ Address _____ _____ NATURE OF BUSINESS: _____ INDUSTRY SIC CODE: _____ Is Applicant exempt from ERISA? Yes <input type="checkbox"/> No <input type="checkbox"/>		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: <input type="checkbox"/> PREFERRED: <input type="checkbox"/> SELECT: <input type="checkbox"/> CHOICE: <input type="checkbox"/> OTHER: ACCESS <input type="checkbox"/> STANDARD OPTION: _____			
Program Deductible: (Ind./Family) \$____/____ \$____/____ \$____/____ Deductible Max Period: Contract Year <input type="checkbox"/> Calendar Year <input type="checkbox"/> Lifetime <input type="checkbox"/> Deductible Applied to all Services: Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Services Exempt from Deductible: Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Ortho <input type="checkbox"/> Program Max: Yr <input type="checkbox"/> Lifetime <input type="checkbox"/> \$____ \$____ \$____ Ortho Max: Yr <input type="checkbox"/> Lifetime <input type="checkbox"/> \$____ \$____ \$____ Waiting Periods (Mos.): Class I ____ Class II ____ Class III ____ Ortho ____		FFS NETWORK REIMBURSEMENT: Advantage <input type="checkbox"/> Advantage Plus <input type="checkbox"/> National FFS <input type="checkbox"/> No Network <input type="checkbox"/> Access <input type="checkbox"/> Pricing -- In ____/____/____ Out ____/____/____ DENTAL PREPAID PRODUCT: PLUS/Third Column: <input type="checkbox"/> Standard Plan _____ Non-Standard Plan: attach detail	
PREMIUM PAYMENT PERIOD: Monthly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Premium must be paid in advance. Checks payable to United Concordia.		GROUP EFFECTIVE DATE: (1st of month) ____/____/____ PRIOR COVERAGE: Yes <input type="checkbox"/> No <input type="checkbox"/> Carrier _____	
PARTICIPATION SUMMARY: ____ # Eligible employees ____ # Enrolled ____ # Waived ____ # Spouse Opt-Outs		DEPENDENT COVERAGE INCLUDES: Spouse <input type="checkbox"/> Children <input type="checkbox"/> Non-Students to Age ____ Students to Age ____ Domestic Partners <input type="checkbox"/>	
RATES: Certificate Holder: _____ Certificate Holder & One Adult: _____ Certificate Holder & One Child: _____ Certificate Holder & Children: _____ Certificate Holder & Family: _____			
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: _____.			
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>			
Applicant: _____ Dated at: _____ (City) _____ (State) By: _____ Producer: _____ SSN#: _____ Title: _____ (Date) _____ Agency: _____ Tax ID: _____ UC Producer ID#: _____ Agency _____ Producer _____			

State Law Provisions

CA:	California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
FL:	Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
AZ, GA, KY, NE & NH:	All statements made by the Policyholder or by any insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.
KS:	Any person who knowingly and with intent to defraud, as stated on this Application, maybe committing a fraudulent insurance act which maybe a crime.
LA:	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and maybe subject to fines and confinement in prison.
IN, MO & ND:	All statements made by the Policyholder or by the persons insured shall be deemed representations and not warranties and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.
NJ:	All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
NY:	Any person who knowingly and with intent to defraud, as stated on this Application, 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.
OR:	Any person who knowingly and with intent to defraud, as stated on this Application, maybe committing a fraudulent insurance act which maybe a crime. Contestability is limited to two years as stated in the Group Policy.
TN:	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
VA:	Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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

Paperwork submitted by:

Name: _____

Phone number: _____

E-mail address: _____

Please indicate (yes or no) if a broker was involved in this transaction: _____

If yes, please provide the following applicable information.

General Agent: _____

Agency: _____

Producing Agent: _____