

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

New York, New York

IAC DENTAL PLANS EMPLOYER APPLICATION AND TRUST ADOPTION AND PARTICIPATION AGREEMENT

EMPLOYER INFORMATION			
Legal Name of Employer:			
Applicant's Phone Number:		Federal Tax ID No.	
Nature of Business:		SIC Code:	
Billing Address:		City:	State: Zip Code:
Street Address (if different from above):		City:	State: Zip Code:
Name of Subsidiaries, Divisions. Locations or Affiliates to be Covered:			
Name and Title of Employer Plan Administrator/Human Resources Contact:		Phone Number: ()	Fax Number: ()
Proposed Effective Date of Insurance:			
Advance payment of \$_____ is submitted herewith to be applied by the Company to premiums for insurance when and if issued.			
ELIGIBILITY			
Eligible Classes: _____ Hours Per Week (Minimum 30 hours per week) <input type="checkbox"/> All Full Time Employees <input type="checkbox"/> Other _____ Number Eligible _____ Note: Permanent part-time employees who average 30 hours per week can be considered eligible for coverage. Any excluded classes of employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details _____		New Hire Waiting Period: <input type="checkbox"/> None <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <i>Employees become eligible for dental benefits the first day of the month following the employer elected waiting period above.</i>	
Effective Date of Coverage / Termination Date of Coverage <input type="checkbox"/> Effective the first day of the month coincident with or next following the date the Employee Benefit Waiting Period is completed and application is approved/terminated on the last day for which premium has been paid.			

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PRIOR CARRIER INFORMATION

If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, give the carrier, the type of coverage and the date the insurance was or is to be discontinued.

Carrier Name

Termination Date

For Credit for Prior Coverage to be considered, this application must be accompanied by a current month's billing from the current carrier, a copy of an in-force certificate and benefit schedule as well as proof of the effective date for each insured individual and dependents, if insured.

DENTAL COVERAGE INFORMATION

Will the employees be required to contribute toward the cost of the insurance? Yes No

If yes, indicate the percentage of the cost the employee will pay.

Coverage	EE Dental	Dep Dental
Employee % or Dollar amount		

Note: If the employer will be paying less than 50% of the premium, voluntary rates apply.

Dental Benefit Plan Selection

Define a dental benefit plan for your employees or select up to 3 plans from which they may choose.

<input type="checkbox"/> Yes If Yes, for group sizes of: 10-49 lives, choose up to 2 plans 50+ lives, choose up to 3 plans			
Employee Choice Groups of 10+ only			
<input type="checkbox"/> No If No, select only one plan below – this coverage will apply to all eligible and enrolling employees.			
Value Plan PPO (Plan 1)	Economy Plan PPO (Plan 2)	Superior Plan PPO (Plan 3)	Superior Plan Indemnity (Plan 4)
<input type="checkbox"/> Value Plan PPO Deductible \$0 Annual Maximum \$250	<input type="checkbox"/> Economy Plan PPO Deductible \$100 lifetime Annual Maximum \$1,000	<input type="checkbox"/> Superior Plan PPO Deductible \$100 lifetime Annual Maximum \$1,500 INCLUDES ORTHO	<input type="checkbox"/> Superior Plan Indemnity Deductible \$100 lifetime Annual Maximum \$1,500 INCLUDES ORTHO
Add-ons for groups of 10+. Employers can select 1 or more packages. All packages will apply to all employees.			
<input type="checkbox"/> Package 1 — Coverage provided for implants and veneers. Available for all plans.		<input type="checkbox"/> Package 3 — Orthodontia (child only). Available for Economy PPO plan only.	
<input type="checkbox"/> Package 2 — Treat Endodontics and Periodontics as basic rather than major services. Available for Economy PPO, Superior PPO and Superior Indemnity plans only.		<input type="checkbox"/> Package 4 — Waiver of the \$100 deductible for Preventative/Diagnostic/Basic/Major services. Available for Economy PPO, Superior PPO and Superior Indemnity plans only.	

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The undersigned Employer ("Employer") hereby applies for coverage under the Group Master Policy ("Policy") issued to the Multiple Unit Security Trust ("Trust") by Standard Security Life Insurance Company of New York ("Insurer"). Employer hereby joins the Trust applies to become Policyholder as a part of its employee welfare benefit plan. Employer agrees that the insurance coverage which is to be placed in force is subject to all of the provisions of the Policy issued to the Trust. Employer agrees to be bound by all of the terms, provisions and limitations of the Trust, the Policy issued thereto, and this Application.

The Employer also agrees that:

- participation in the Trust is subject to written approval of this Employer Application by Insurer or its designee; no liability is created for, or assumed by, the Trust or Insurer until this application has been approved in writing; acceptance of the check submitted with the application does not constitute approval or guarantee coverage; and if for any reason this application is not so approved in writing, the sole obligation of the Trust and Insurer will be, and the Employer shall be entitled to only, a refund of any monies paid.
- the first premium payment is due as of the date coverage becomes effective; subsequent premiums are due on the first day of each succeeding month; a grace period of 31 days will be allowed for the payment of any premium due after the initial premium.
- it has reviewed all of the answers to the questions on this Employer Application; understands that it is Employer's responsibility to provide truthful, complete and accurate information; represents that all of the information contained herein is true and complete; acknowledges that any material misstatements or failure to report information by Employer or Employees may be used as the basis of rescission or termination of Employer's or any Employees coverage.
- its agent is an independent insurance agent representing Employer, not the Insurer, and that no agent is authorized or has authority to (1) alter the terms of the Policy or the Trust; (2) waive, alter or modify any questions on this Employer Application; or (3) permit Employer or Employees to inaccurately answer any questions.
- it must maintain the minimum Participation Requirements stated herein; Insurer may periodically request and inspect payroll and personnel records to verify Employee participation rates; Employer will provide any such information that is requested; Employer's failure or refusal to provide such information is ground for termination of coverage; and Employers failure to maintain minimum participation requirements may result in coverage termination or loss of protection.
- I understand and agree that if, on the effective date, an employee is not in regular, full-time active work, coverage for such employee shall be deferred until such employee qualifies for coverage in accordance with the Master Policy provisions (i.e. the employee is actively at work).
- I understand that my application and any coverage provided under the Master Policy is a part of my Employee Welfare Benefit Plan established for my employees, certain rights granted by the "Employee Retirement Income Security Act of 1974" (ERISA) apply to all participants, and I retain all plan sponsor, plan administrator and plan fiduciary responsibilities under ERISA.

I understand that this enrollment form requests our participation in a Multiple Employer Trust. I agree to be bound by the terms of the trust agreement, a copy of which will be furnished to me upon my request.

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WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

ARKANSAS: 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 may be subject to fines or confinement in prison.

KANSAS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraudulent act against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud as determined by a court of law.

OHIO: Any person who, with 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 is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: 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 subjects such person to criminal and civil penalties.

I acknowledge I am advised not to terminate any existing dental coverage plans for my Employees and myself until my Agent receives notification this Application has been approved by Standard Security Life Insurance Company of New York.

Dated at: _____ this _____ day of _____, 20__

Signature of Writing Agent

Agent Code

Applicant's Signature (Owner or Officer)

Signature of Other Agent(s)

Agent Code

Type or Print Applicant's Name and Title

Agency Name

Agent's Phone Number

Agent's Business Address

City

State

Zip

Employer: Attach the most recent quarterly wage and tax statement to this application.

SPECIAL REQUESTS

Send Administration Kit, Certificates, and ID Cards to: **Broker** **Employer**

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General Agent's Name

General Agent's Phone

General Agent's Fax