Group Dental Programs

Administered by:

Dutcher Insurance Agency, Inc.

Lic. #0561264

For Members of the National Council of Independent Consumers Association

Underwritten by:
SafeHealth Life
Insurance Company

EMPLOYER APPLICATION & PARTICIPATION AGREEMENT

GROUP NO.

The undersigned employer makes application to SafeHealth Life Insurance Co. and hereby agrees to: (1) to cover himself and, if a partnership, all active partners, or if a corporation, all officers active in the conduct of such corporation, (2) to make such insurance, as applies to employees, available to all eligible employees and all employees becoming eligible in the future, and (3) to make payroll deductions as required for the plans of insurance as are applicable to employees.

It is understood that only those employees who meet the eligibility requirements are to be included and that participation requirements must be met before the insurance can be made effective. Participation Effective Dates, and contribution requirements are described under the heading, "Underwriting Rules." Failure to maintain minimum levels for participation, group size and contribution requirements may result in cancellation of coverage.

The undersigned employer agrees to contribute 100 % of the cost of the employees coverage and ______% of the cost of dependent coverage. There are initially ______ full-time eligible employees of which ______ are enrolled in this program. If ALL eligible employees are not enrolled, explain why: ______________________.

1. Employer's Firm Name ______________________

   Address ______________________

   Telephone (______)______________ Correspondence to ______________ Title ______________

   State whether this is a: ☐ sole proprietor; ☐ corporation; ☐ partnership; ☐ other: ______________

   Nature of Business ______________________

2. Desired effective date (limited to the first of the month): _____/_____/_____

For Office Use Only:

Effective Date _____/_____/_____ Plan Code ____________ Area Fee ____________ Transfer ____________ PED ____________

TAKEOVER PROVISIONS

A. There is a 12-month Benefit Waiting Period for Type 3 Major Procedures from the day that the Insured Person's coverage goes into effect. This limitation may be waived for individuals insured as part of a group of 10 or more employees who are replacing existing comparable ***dental coverage,*** provided the individual's coverage has been in force at least 12 consecutive months immediately prior to the effective date of this policy.

B. There is a 12-month Benefit Waiting Period for Type 4 Orthodontia Benefits from the day that the Insured Person's coverage goes into effect. This limitation may be waived for individuals insured as part of a group of 10 or more employees who are replacing existing ***orthodontia coverage,*** provided the individual's coverage has been in force at least 12 consecutive months immediately prior to the effective date of this policy.

C. Are employees of the applicant firm eligible for a Benefit Waiting Period Waiver? ☐ Yes ☐ No

   If Yes: Type 3 Major Procedures Only ☐ ***OR*** Type 3 Major Procedures and Type 4 Orthodontia Benefits ☐

   The agent has no authority to grant a waiver of these Waiting Periods or to alter these or any other provisions of the policy. The administrator will advise the employer if a Benefit Waiting Period Waiver will be granted to any individual Insured Person subject to verification of above qualifications being met.

   In order to obtain the applicable Benefit Waiting Period Waiver, a copy of the existing dental or dental/ orthodontia plan of benefits and a copy of the carrier's last billing statement must be submitted, and an additional premium paid (see reverse).

4. Initial waiting period required: (a) for employees on the effective date — NONE; (b) for future employees: ☐ 30 days; ☐ 60 days; ☐ 90 days. The undersigned Employer requests that insurance be made available to all the Employer's eligible and designated employees, subject to the terms and requirements of the group insurance policy(ies) and further subject to the following conditions:

   A. No coverage for any employee shall take effect until this application and the employee's individual enrollment forms are accepted and the initial premium paid.

   B. Employer agrees to remit regularly in advance the required premium payments and acknowledges that coverage of eligible employees will terminate if premium payments are not received when due or within the applicable grace period.

UNDERWRITING RULES

Contribution, Participation, Group Size — The minimum Employer contribution shall be 100% of the Employee Only Premium and 100% of all eligible employees must be enrolled. If dependent coverage is to be provided not less than 50% of eligible dependents must be enrolled.

Ineligible Firms — Bail bondsmen; bands or orchestras; barber and beauty shops; bar rooms; cocktail lounges and clubs; collection agencies; dental offices; entertainers; gambling businesses; gyms; junk dealers; limousine services; massage parlors; parking lots and garages; pawn shops; pool halls; taxi companies; and those groups where more than half the employees are related by blood or marriage are not acceptable for coverage. This list is representative and not inclusive. The administrator reserves the right to reject any firm which does not conform to sound underwriting principles.

Effective Dates — The effective date of a Member Employer shall be limited to the first of the month. Eligibility for present Employees will be the initial effective date, while new hires will be on the first of the month following completion of the waiting period selected by the Employer. If an employee is not working full time on the date coverage would otherwise take effect, coverage is deferred until the employee returns to active full-time employment.

Premiums & Service Charges — Applicable Premium Rates are guaranteed for each Member Employer for 6 months from the date of issue. Thereafter, rates are subject to change in accordance with the master policy. On each billing a charge will be made to cover costs incurred by the Administrator in billing and collecting from each Member Employer.

Signature of Company Officer ______________________ Print Name and Title ______________________

Dated at ______________________ This ______ Day of ______________________, 20,______

PRODUCER STATEMENT

I hereby certify that all the information contained herein is correct to the best of my knowledge and I know nothing unfavorable about this firm or any individual proposed for coverage. I have complied with underwriting rules and regulations and have explained, in detail, the coverages, limitations and exclusions of the plan to the firm.

Name ______________________ SS# ______-______-______

Address ______________________ City ______________________ State ______ Zip ______

Telephone (______)______________ Agent # ______________ General Agent # ______________

PREMIUM CALCULATION

AREA	TYPE OF COVERAGE	NUMBER	PREMIUM AMOUNT	TOTAL
	Employee Only	______	@ $______	= $______
	Employee Plus 1	______	@ $______	= $______
	Employee Plus 2 or more	______	@ $______	= $______

Total Premium . . . . $______

For Takeover Provision, Add 10% . . . . $______

Monthly Administration Fee . . . . $ 20.00

Monthly Association Fee . . . . ______ . . . . @ $ 2.00 = $______
($2 per employee)

TOTAL MONTHLY PREMIUM . . . . $______

Initial Enrollment Fee . . . . ______ . . . . @ $ 10.00 = $______
($10 per employee / $100 maximum)

TOTAL AMOUNT DUE WITH APPLICATION . . . . $______

Make checks payable to: **DUTCHER INSURANCE AGENCY, INC.**