



Dental · Life · Disability · Vision

### Application for Group Dental Coverage

Submit Application to Your Local TDA Office:

TDA - Arizona  
2111 East Highland Avenue, Suite 250  
Phoenix, AZ 85016  
(602) 266-1995, (888) 422-1995

TDA - Utah  
6985 Union Park Center, Suite 675  
Salt Lake City, UT 84047  
(801) 268-9873, (800) 880-3536

Application is made to Companion Life Insurance Company for a Dental Policy, the provisions of which shall be made available to all eligible classes of Employees.

### GENERAL INFORMATION

#### 1. APPLICATION FOR DENTAL

- a. Type of coverage(s):  PPO  PPO/MAC  EPO  Elite Choice  Other (Specify) \_\_\_\_\_
- b. Term of Contract:  One Year  Two Year  Other (Specify) \_\_\_\_\_
- c. Requested effective date: \_\_\_\_\_  
(Mo.) (Day) (Year)

#### 2. EMPLOYER

- a. Full legal name: \_\_\_\_\_
- b.  Corporation  Proprietorship  Partnership
- c. Contact Person: \_\_\_\_\_ (E-mail) \_\_\_\_\_
- d. Employer Identification Number (EIN): \_\_\_\_\_
- e. Primary business address in state policy is issued:  
\_\_\_\_\_  
(Street) (City) (State) (Zip)
- f. Billing address (if different than above):  
\_\_\_\_\_  
(Street) (City) (State) (Zip)
- g. Telephone Number: ( ) - \_\_\_\_\_ - \_\_\_\_\_
- h. Nature of Business: \_\_\_\_\_ SIC Code: \_\_\_\_\_
- i. Affiliates or subsidiaries to be covered (use "Additional Information on page 4 for this if more space is needed):

_____ (Full Legal Name)	_____ (Full Legal Name)
_____ (Street Address)	_____ (Street Address)
_____ (City, State, Zip)	_____ (City, State, Zip)
_____ (Nature of Business)	_____ (Nature of Business)

- j. Number of eligible employees residing outside of the state in which the policy was issued:  
\_\_\_\_\_  
(State and number of employees)
- \_\_\_\_\_  
(State and number of employees)
- \_\_\_\_\_  
(State and number of employees)
- \_\_\_\_\_  
(State and number of employees)

**3. OTHER COVERAGE INFORMATION**

- a. Will this coverage supplement other Dental coverage?  Yes  No  
If yes, what other coverage will be provided? \_\_\_\_\_
- b. Will alternative coverage through a DHMO or other capitation plan be offered?  Yes  No  
If yes, show name of capitation plan. \_\_\_\_\_
- c. Will this coverage replace a current program?  Yes  No  
If yes, who is the current carrier? \_\_\_\_\_

**ELIGIBILITY**

**1. CLASSES OF ELIGIBLE EMPLOYEES**

- a. Active employees
  - ◆ All active full-time employees (A full-time employee must work 30 hours per week of compensable time.)
  - ◆ Specific class or class's only (Specify class, such as hourly, salaried, covered or not covered by collective bargaining, etc.): \_\_\_\_\_
- b. Other - Explain if there are any persons who will be enrolled who are not actively employed: i.e., retirees, COBRA, etc.: \_\_\_\_\_

**2. NUMBER OF ELIGIBLE EMPLOYEES IN ELIGIBLE CLASSES**

- a. Total number of employees on the payroll \_\_\_\_\_
- b. Less number of employees not eligible
  - 1) Temporary or seasonal employees (\_\_\_\_\_)
  - 2) Employees working less than 30 hours per week (\_\_\_\_\_)
  - 3) Employees serving probationary period (\_\_\_\_\_)
  - 4) Employees enrolled in a DMO or Capitation plan (\_\_\_\_\_)
  - 5) Total ineligible employees (\_\_\_\_\_)
- c. Net eligible employees (a minus b.5) (\_\_\_\_\_)
- d. Number of eligible employees who will not be enrolled. Specify Reason: \_\_\_\_\_ (\_\_\_\_\_)
- e. Number of eligible employees who will be enrolled. (c minus d) \_\_\_\_\_

*\*A \$10.00 per month administration fee will be charge for groups with less than 25 enrolled*

**3. DEPENDENT ELIGIBILITY**

Spouse and/or unmarried children to age 19 or to age 26 if unmarried. If there are any additional eligibility requirements for dependents, please specify:

**4. ENROLLMENT**

To enroll, timely application must be made to Companion Life Insurance Company. Eligible employees must submit a completed application card to the Employer within 30 days following completion of a: Specify amount (\_\_\_\_\_) day probationary period. (Example 0, 30, 60, 90)

Application for addition of newly acquired eligible dependents through marriage must be submitted to Companion Life Insurance Company, through the Employer, within 30 days of marriage.

Application for continuation of coverage for newborn children of the insured employee and spouse and/or newly acquired adopted children must be submitted within 60 days of the date of birth of the natural child or within 60 days of placement for adoption in the employee's home of a child which is to be adopted.

**NOTE:** ELIGIBLE employees or their dependents who do not enroll when they first become eligible may make application for enrollment only during the group' annual open enrollment period unless the Employer is contributing 100 percent of the cost of the individual coverage (see "Employer's Contributions" below) and has agreed or is required to make retroactive payment of premium charges.

---

## EMPLOYERS CONTRIBUTIONS

---

**1. PERCENT OR AMOUNT**

The Employer agrees to make the following contribution toward the cost of the employee and dependent coverage:

Employee	_____	%
Dependent	_____	%

**2. RETROACTIVE COVERAGE**

If the Employer pays 100% of employee and/or dependent coverage, eligible individuals who did not enroll when first eligible will have retroactive coverage from the date of first eligibility upon payment of retroactive premium.

Yes  No

**THIS PAGE  
INTENTIONALLY LEFT  
BLANK**

**PLAN 1 DESCRIPTION**

1. **PLAN NAME AND TYPE:** \_\_\_\_\_ (Example High, Low)  PPO  PPO/MAC  EPO  Elite Choice  Other \_\_\_\_\_

- Plan A - Endodontics and Periodontal Services as Class II Benefits
- Plan B - Endodontics and Periodontal Services as Class III Benefits
- Custom -
 

Basic Endodontics (Root Canals)	Class _____
Major Endodontics	Class _____
Periodontics	Class _____
Simple Extractions	Class _____
Surgical Extractions	Class _____
Implants	Class _____

**DEDUCTIBLE**

Waived for Class I  Yes  No  
 Per person: \$ \_\_\_\_\_  
 Per Family \$ \_\_\_\_\_

**MAXIMUM BENEFIT PER YEAR**

Per Person \$ \_\_\_\_\_  
 Per Calendar Year for all Covered Dental Benefits - (Class I, II, and Class III)

**THE POLICY WILL PAY - "IN-NETWORK"**

Class I: Preventative \_\_\_\_\_ %  
 Class II: Basic \_\_\_\_\_ %  
 Class III: Major \_\_\_\_\_ %

**THE POLICY WILL PAY - "OUT-OF-NETWORK" of the Allowable Fee\***

Class I: Preventative \_\_\_\_\_ %  
 Class II: Basic \_\_\_\_\_ %  
 Class III: Major \_\_\_\_\_ %

Twelve (12) Month Waiting Period Apply to Class III?  Yes  No  
 Credit given for time covered under this employer's prior Plan?  Yes  No  N/A

Class IV: Ortho\*\* \_\_\_\_\_ %

Twelve (12) Month Waiting Period Apply to Class IV?  Yes  No  
 Credit given for time covered under this employer's prior Plan?  Yes  No  N/A  
 Adult Ortho Included?  Yes  No

The Orthodontic Lifetime Maximum (if applicable): \$ \_\_\_\_\_

**ADDITIONAL CONTRACT MODIFICATIONS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLAN 2 DESCRIPTION** (if applicable)

2. PLAN NAME AND TYPE: \_\_\_\_\_ (Example High, Low)  PPO  PPO/MAC  EPO  Elite Choice  Other \_\_\_\_\_

- Plan A - Endodontics and Periodontal Services as Class II Benefits
- Plan B - Endodontics and Periodontal Services as Class III Benefits
- Custom -
 

Basic Endodontics (Root Canals)	Class _____
Major Endodontics	Class _____
Periodontics	Class _____
Simple Extractions	Class _____
Surgical Extractions	Class _____
Implants	Class _____

**DEDUCTIBLE**

Waived for Class I  Yes  No  
 Per person: \$ \_\_\_\_\_  
 Per Family \$ \_\_\_\_\_

**MAXIMUM BENEFIT PER YEAR**

Per Person \$ \_\_\_\_\_  
 Per Calendar Year for all Covered Dental Benefits - (Class I, II, and Class III)

**THE POLICY WILL PAY - "IN-NETWORK"**

Class I: Preventative \_\_\_\_\_%  
 Class II: Basic \_\_\_\_\_%  
 Class III: Major \_\_\_\_\_%

**THE POLICY WILL PAY - "OUT-OF-NETWORK" of the Allowable Fee\***

Class I: Preventative \_\_\_\_\_%  
 Class II: Basic \_\_\_\_\_%  
 Class III: Major \_\_\_\_\_%

Twelve (12) Month Waiting Period Apply to Class III?  Yes  No  
 Credit given for time covered under this employer's prior Plan?  Yes  No  N/A

Class IV: Ortho\*\* \_\_\_\_\_%

Twelve (12) Month Waiting Period Apply to Class IV?  Yes  No  
 Credit given for time covered under this employer's prior Plan?  Yes  No  N/A  
 Adult Ortho Included?  Yes  No

The Orthodontic Lifetime Maximum (if applicable): \$ \_\_\_\_\_

**ADDITIONAL CONTRACT MODIFICATIONS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLAN 3 DESCRIPTION** (if applicable)

3. PLAN NAME AND TYPE: \_\_\_\_\_ (Example High, Low)  PPO  PPO/MAC  EPO  Elite Choice  Other \_\_\_\_\_

- Plan A - Endodontics and Periodontal Services as Class II Benefits
- Plan B - Endodontics and Periodontal Services as Class III Benefits
- Custom -
 

Basic Endodontics (Root Canals)	Class _____
Major Endodontics	Class _____
Periodontics	Class _____
Simple Extractions	Class _____
Surgical Extractions	Class _____
Implants	Class _____

DEDUCTIBLE

Waived for Class I  Yes  No  
 Per person: \$ \_\_\_\_\_  
 Per Family \$ \_\_\_\_\_

MAXIMUM BENEFIT PER YEAR

Per Person \$ \_\_\_\_\_  
 Per Calendar Year for all Covered Dental Benefits - (Class I, II, and Class III)

THE POLICY WILL PAY - "IN-NETWORK"

Class I: Preventative \_\_\_\_\_ %  
 Class II: Basic \_\_\_\_\_ %  
 Class III: Major \_\_\_\_\_ %

THE POLICY WILL PAY - "OUT-OF-NETWORK" of the Allowable Fee\*

Class I: Preventative \_\_\_\_\_ %  
 Class II: Basic \_\_\_\_\_ %  
 Class III: Major \_\_\_\_\_ %

Twelve (12) Month Waiting Period Apply to Class III?  Yes  No  
 Credit given for time covered under this employer's prior Plan?  Yes  No  N/A

Class IV: Ortho\*\* \_\_\_\_\_ %

Twelve (12) Month Waiting Period Apply to Class IV?  Yes  No  
 Credit given for time covered under this employer's prior Plan?  Yes  No  N/A  
 Adult Ortho Included?  Yes  No

The Orthodontic Lifetime Maximum (if applicable): \$ \_\_\_\_\_

ADDITIONAL CONTRACT MODIFICATIONS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLAN 4 DESCRIPTION** (if applicable)

4. PLAN NAME AND TYPE: \_\_\_\_\_ (Example High, Low)  PPO  PPO/MAC  EPO  Elite Choice  Other \_\_\_\_\_

- Plan A - Endodontics and Periodontal Services as Class II Benefits
- Plan B - Endodontics and Periodontal Services as Class III Benefits
- Custom -
 

Basic Endodontics (Root Canals)	Class _____
Major Endodontics	Class _____
Periodontics	Class _____
Simple Extractions	Class _____
Surgical Extractions	Class _____
Implants	Class _____

**DEDUCTIBLE**

Waived for Class I  Yes  No  
 Per person: \$ \_\_\_\_\_  
 Per Family \$ \_\_\_\_\_

**MAXIMUM BENEFIT PER YEAR**

Per Person \$ \_\_\_\_\_  
 Per Calendar Year for all Covered Dental Benefits - (Class I, II, and Class III)

**THE POLICY WILL PAY - "IN-NETWORK"**

Class I: Preventative \_\_\_\_\_ %  
 Class II: Basic \_\_\_\_\_ %  
 Class III: Major \_\_\_\_\_ %

**THE POLICY WILL PAY - "OUT-OF-NETWORK" of the Allowable Fee\***

Class I: Preventative \_\_\_\_\_ %  
 Class II: Basic \_\_\_\_\_ %  
 Class III: Major \_\_\_\_\_ %

Twelve (12) Month Waiting Period Apply to Class III?  Yes  No  
 Credit given for time covered under this employer's prior Plan?  Yes  No  N/A

Class IV: Ortho\*\* \_\_\_\_\_ %

Twelve (12) Month Waiting Period Apply to Class IV?  Yes  No  
 Credit given for time covered under this employer's prior Plan?  Yes  No  N/A  
 Adult Ortho Included?  Yes  No

The Orthodontic Lifetime Maximum (if applicable): \$ \_\_\_\_\_

**ADDITIONAL CONTRACT MODIFICATIONS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

---

**PREMIUMS AGREED TO**

---

**Dental Plan 1** \_\_\_\_\_ **Plan Name** \_\_\_\_\_

Option 1. **2 - Tier**                       **3 - Tier**                       **4 - Tier**

Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month

**Dental Plan 2** \_\_\_\_\_ **Plan Name** \_\_\_\_\_

Option 2. **2 - Tier**                       **3 - Tier**                       **4 - Tier**

Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month

**Dental Plan 3** \_\_\_\_\_ **Plan Name** \_\_\_\_\_

Option 3. **2 - Tier**                       **3 - Tier**                       **4 - Tier**

Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month

**Dental Plan 4** \_\_\_\_\_ **Plan Name** \_\_\_\_\_

Option 4. **2 - Tier**                       **3 - Tier**                       **4 - Tier**

Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month

**Vision Plan** \_\_\_\_\_ (if applicable)

Vision. **2 - Tier**                       **3 - Tier**                       **4 - Tier**

Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month



1. Initial amount submitted with this Application \$ \_\_\_\_\_

Please attach a copy of the initial Census.

**ADDITIONAL INFORMATION**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Agreement

- a. This application is signed by a person or persons authorized by the Employer to make such an agreement; and
- b. The application is received and approved by the Companion Life Insurance Company (TDA) at its home office; and
- c. The initial month's premium is received by Companion Life Insurance Company (TDA).

This application will become part of the Group Dental Policy issued to the Employer. Coverage is effective on the first billing due date after the conditions in (a), (b), and (c) above have been met. Coverage is subject to all the terms and conditions of the Group Dental Policy.

3. Signatures

For a corporation, the President or Vice President and the Secretary or Acting Secretary should sign. For a proprietorship, the owner should sign. For a partnership, any partner should sign.

I have read this application, agreed to the terms, and certify that all statements are true and complete. It is understood that provisions of the Group Dental Policy, including premiums therefore, may be amended or changed from time to time, upon written notice from Companion Life Insurance Company (TDA) to the Employer.

By \_\_\_\_\_  
(print name)

\_\_\_\_\_  
(sign name)

Title \_\_\_\_\_

Date \_\_\_\_\_

Witnessed by:

\_\_\_\_\_  
(print agent's name)

By \_\_\_\_\_  
(sign agent's name)

Date \_\_\_\_\_

General Agent (if applicable):

\_\_\_\_\_  
(print agent's name)

By \_\_\_\_\_  
(sign agent's name)

Date \_\_\_\_\_