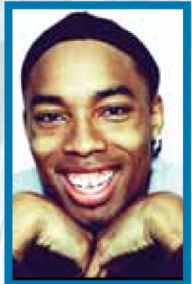
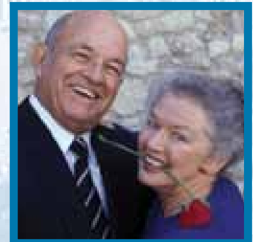
Discover the Dental Insurance Plan that helps you reach new heights.





peak & summit plans

Dual Choice

CONNECTICUT

Higher Level Dental Care

G R O U P S 2 +

Employer Group Dental Insurance Form MNL GDEN-POL 0505 underwritten by Madison National Life Insurance Company, Inc., and in NH and NY by Standard Security Life Insurance Company of New York Form SSL GDEN-POL 0505.

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DBDEN600

Now you can offer to employers a group dental insurance plan – and choose who pays for it. With the Denali Dental program, workers receive high quality group plans at affordable group rates and pay for the benefits pre-tax.

It's the best of both worlds. Your clients conserve cash, and their employees get the single most requested employee benefit. They will appreciate the chance at getting coverage, while the employer gets to choose who picks up the bill.*

Peak PPO/Summit Select Dual Choice Option

Employees who choose a PPO network dentist offered by DenteMAX will save 20 - 35% in out-of-pocket expenses and premiums.

Summit Select Any Dentist

Covered employees and their families are free to visit the dentist of their choice. In fact, each family member may visit a different dentist. Benefits are paid on usual and customary charges.

No Waiting Periods

Including immediate coverage for Preventive, Basic and Major Services.

Low Participation Requirements for Voluntary Groups

Groups need only meet the greater of 2 enrolled or 20% of eligible employee lives.

Section 125 Eligibility

Premiums qualify for pre-taxed savings utilizing IRS code Section 105 or 125.

Optional $1200 Orthodontia Benefits (Additional Premium)

Minimum of 2 enrolled employees are required.

Takeover Credit

Reduced Type III benefit periods will be offset by the amount of time that major benefits were payable under the prior group dental plan. This applies to only employees who are currently covered under the group policy and only at initial enrollment. Future new hires will not receive this credit.

Optional Vision (Additional Premium)

Coverage for exams, contacts, frames, and lenses. Choose from 2 plan designs.

* *2005 LIMRA Study*

Denali Dental Groups 2-100 (Peak & Summit)

Covered Services	Peak PPO Network	Summit Select Any Dentist
Preventive Services (Type I) Routine exams and cleanings (one every six months), periapicals. Flouride treatments limited to dependents under age 19 once every 12 months. Bitewing x-rays (set of 4) once per 12 months.	**100%**	**100%**
Basic Services (Type II) Routine fillings (amalgam and resin restorations), palliative treatments. Sealants for dependents under age 14 limited to one treatment per permanent molar in a 36 month period. Space Maintainers limited to dependents under age 14 including adjustments within the 6 month period following installation.	**90%**	**80%**
Major Services (Type III) Bridges, Crowns, Dentures, Inlays, Onlays. Endodontics (root canals), Periodontics (gum treatment), simple extractions. Oral Surgery, General Anesthesia, Denture Relines & Rebases. Full mouth X-Rays limited to one set per a 36 month period. Surgical Placement of Implant limited to one per lifetime. Veneers - including cosmetic.	**10% 1st 12 mos 60% thereafter**	**10% 1st 12 mos 50% thereafter**
Waiting Periods	**None**	**None**
Lifetime Deductible This deductible applies to all covered dental services (Preventive, Basic and Major Combined).	**$100 per person**	**$100 per person**
Annual Maximum Per Person	**$2,000**	**$1,000***
Takeover Credit Available	**Yes****	**Yes****
Twelve (12) Month Rate Guarantee	**Yes**	**Yes**

Brochure-rated plans for groups 2-100 eligible lives

* *Optional $1,500 or $2,000 annual maximum benefit available. Optional Orthodontia, $1,200 lifetime maximum, covered at 50% with a 12 month wait period.*

** *Copy of Prior Plan schedule of Benefits, last billing statement, and each employee's effective date required. Takeover credits apply to Transfer Insureds only. Major Services for takeover groups must have been in benefit for a minimum of 12 months.*

www.directbenefits.com

www.dentemax.com

MONTHLY PREMIUMS – 75% PARTICIPATION DUAL CHOICE 2+

PEAK PPO 2-9 LIFE GROUPS 75% PARTICIPATION AFTER ELIGIBLE WAIVERS

	Region A	Region B	Region C	Region D	Region E	Region F	Region G	Region H	Region I	Region J
Employee	$28.72	$27.03	$28.31	$26.11	$33.24	$26.42	$29.80	$25.31	$31.27	$26.78
Employee +1	$55.79	$52.42	$54.99	$50.58	$64.87	$51.17	$57.96	$49.02	$57.52	$51.93
Family	$86.92	$81.63	$85.66	$78.74	$101.23	$79.66	$90.33	$76.25	$91.31	$80.83

PEAK PPO 10-100 LIFE GROUPS 75% PARTICIPATION AFTER ELIGIBLE WAIVERS

	Region A	Region B	Region C	Region D	Region E	Region F	Region G	Region H	Region I	Region J
Employee	$26.13	$24.62	$25.78	$23.79	$30.28	$24.05	$27.13	$23.06	$28.45	$24.37
Employee +1	$50.79	$47.72	$50.07	$46.06	$59.05	$46.60	$52.76	$44.63	$55.43	$47.28
Family	$79.14	$74.31	$78.01	$71.69	$92.15	$72.52	$82.25	$69.43	$89.47	$73.61

SUMMIT SELECT 2-9 LIFE GROUPS 75% PARTICIPATION AFTER ELIGIBLE WAIVERS

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee	$24.27	$27.27	$29.97	$32.66	$35.66	$38.35	$41.96	$47.94
Employee +1	$48.55	$54.54	$59.93	$65.33	$71.33	$76.72	$83.91	$95.90
Family	$75.25	$84.54	$92.90	$101.26	$110.55	$118.91	$130.06	$148.63

SUMMIT SELECT 10-100 LIFE GROUPS 75% PARTICIPATION AFTER ELIGIBLE WAIVERS

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee	$22.10	$24.83	$27.28	$29.74	$32.47	$34.92	$38.19	$43.65
Employee +1	$44.20	$49.65	$54.57	$59.47	$64.93	$69.84	$76.39	$87.31
Family	$68.51	$76.97	$84.57	$92.19	$100.64	$108.26	$118.42	$135.33

PLAN OPTIONS

OPTIONAL $0 ZERO DEDUCTIBLE
Multiply rates by 1.20.

OPTIONAL $25/$75 CALENDAR YEAR DEDUCTIBLE PER PERSON/FAMILY THAT APPLIES TO CLASS II AND III. Multiply rates by 1.17.

OPTIONAL $50/$150 CALENDAR YEAR DEDUCTIBLE PER PERSON/FAMILY THAT APPLIES TO CLASS II AND III. Multiply rates by 1.12.

ENDO/PERIO TO BASIC (TYPE II)
Multiply rates by 1.10.

$1500 SUMMIT SELECT ANNUAL MAXIMUM PER PERSON
Multiply rates by 1.08.

$2000 SUMMIT SELECT ANNUAL MAXIMUM PER PERSON
Multiply rates by 1.14.

ORTHODONTIA RATES ($1200 lifetime maximum for adults and children)

Orthodontia can be added to groups with a minimum of 2 enrolled employees. Orthodontia can be added to any of the above plans by adding these rates to the selected rate above. Orthodontia is covered at 50%, with a 12 month wait, and a $600 annual maximum.

	Employee	Employee +1	Family
2-4 lives	$2.50	$10.56	$19.48
5-9 lives	$1.43	$6.03	$11.13
10-100 lives	$1.30	$5.49	$10.13

EXCLUDED INDUSTRIES

Excluded Industries:

Dentists and dental related industries

Rated Industries (20% load):

Schools
Municipalities
Government
Hospitals
Lawyers and law offices

Rates are effective through June 30, 2012.

NOTE: A monthly administration fee of $15 will be added to each employer group. (Waived if paying by ACH bank draft.)

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MONTHLY PREMIUMS – VOLUNTARY DUAL CHOICE 2+

PEAK PPO 2-9 LIFE GROUPS VOLUNTARY

	Region A	Region B	Region C	Region D	Region E	Region F	Region G	Region H	Region I	Region J
Employee	$29.78	$27.94	$29.35	$26.93	$34.78	$27.25	$30.97	$26.05	$32.57	$27.65
Employee +1	$59.56	$55.85	$58.70	$53.84	$69.54	$54.51	$61.96	$52.12	$65.17	$55.33
Family	$93.80	$87.99	$92.45	$84.81	$109.55	$85.71	$97.57	$82.07	$102.64	$87.12

PEAK PPO 10-100 LIFE GROUPS VOLUNTARY

	Region A	Region B	Region C	Region D	Region E	Region F	Region G	Region H	Region I	Region J
Employee	$26.97	$25.44	$26.72	$24.49	$31.65	$24.82	$28.20	$23.71	$29.66	$25.18
Employee +1	$54.22	$50.87	$53.43	$49.03	$63.33	$49.62	$56.40	$47.45	$59.34	$50.36
Family	$85.39	$80.12	$84.16	$77.23	$99.73	$78.15	$88.82	$74.74	$93.46	$79.33

SUMMIT SELECT 2-9 LIFE GROUPS VOLUNTARY

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee	$26.70	$29.99	$32.96	$35.93	$39.24	$42.20	$46.16	$52.74
Employee +1	$53.40	$60.00	$65.93	$71.87	$78.45	$84.39	$92.29	$105.48
Family	$86.15	$92.99	$102.18	$111.39	$121.61	$130.80	$143.07	$163.51

SUMMIT SELECT 10-100 LIFE GROUPS VOLUNTARY

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee	$24.31	$27.31	$30.01	$32.71	$35.72	$38.42	$42.01	$48.02
Employee +1	$48.62	$54.63	$60.02	$65.43	$71.43	$76.83	$84.05	$96.03
Family	$75.36	$84.66	$96.40	$101.40	$107.35	$119.09	$130.25	$148.87

PLAN OPTIONS

OPTIONAL $0 ZERO DEDUCTIBLE
Multiply rates by 1.20.

OPTIONAL $25/$75 CALENDAR YEAR DEDUCTIBLE PER PERSON/FAMILY THAT APPLIES TO CLASS II AND III. Multiply rates by 1.17.

OPTIONAL $50/$150 CALENDAR YEAR DEDUCTIBLE PER PERSON/FAMILY THAT APPLIES TO CLASS II AND III. Multiply rates by 1.12.

ENDO/PERIO TO BASIC (TYPE II)
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$1500 SUMMIT SELECT ANNUAL MAXIMUM PER PERSON
Multiply rates by 1.08.

$2000 SUMMIT SELECT ANNUAL MAXIMUM PER PERSON
Multiply rates by 1.14.

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Dentists and dental related industries

Rated Industries (20% load):

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Municipalities
Government
Hospitals
Lawyers and law offices

Rates are effective through June 30, 2012.

NOTE: A monthly administration fee of $15 will be added to each employer group. (Waived if paying by ACH bank draft.)

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PEAK PPO REGION FACTORS

Alabama	350-369	F
Alaska	995-999	E
Arkansas	716-729	H
Arizona	850-865	G
California	900-931, 939-941	E
	943-951	E
	932-938, 942, 952-961	I
Colorado	800-804, 808-810, 816	I
	805-807, 811-815	C
	817-819	C
Connecticut	060-069	E
Deleware	197-199	I
Dist. of Columbia	200, 202-205	E
Florida	320-322, 326-329	B
	335-338, 342-347	B
	323-325	F
	330-334, 339-341, 349	E
Georgia	300-303, 311	I
	304-309, 313-315	B
	310, 312, 316-319	F
Hawaii	967-968	E
Idaho	832-839	F
Illinois	600-606, 611	C
	607-610, 612-629	D
Indiana	460-466, 469, 473, 479	C
	467, 468, 470-472	B
	474-478	B
Iowa	500-528	F
Kansas	663-679	F
	660-662	J
Kentucky	400-406, 410	D
	420-424, 427	D
	407-409, 411-419	H
	425, 426	H
Louisana	700-715	F
Maine	039-049	I
Maryland	206, 207, 210-219	C
	208, 209	E
Massachusetts	010-016	I
	017-027	E
Michigan	480-499	A
Minnesota	550-555	I
	556-569	C
Mississippi	386-399	C
Missouri	630-634, 640-641	J
	635-639, 642-659	D
Montana	590-599	F
Nebraska	680-699	H
Nevada	889-892	I
	893-899	E
New Hampshire	030-038	I
New Jersey	070-079, 085, 086	E
	088, 089	E
	080-084, 087	I
New Mexico	870-884	C
New York	100-119	E
	120-129	B
	130-149	F
North Carolina	270-289	G
North Dakota	580-588	C
Ohio	430-432, 440-447	D
	450-455	D
	433-439, 448, 449	B
	456-458	B
Oklahoma	730-749	D
Oregon	970-979	I
Pennsylvania	150-179, 182, 184-188	D
	180, 181, 183, 189-196	I
Rhode Island	028-029	C
South Carolina	290-299	B
South Dakota	570-579	H
Tennessee	370-385	D
Texas	750-753, 760-763	C
	770-775, 786, 787, 789	C
	754-759, 764-769	F
	776-779, 783-785	F
	788, 790-799, 885	F
	780-782	B
Utah	840-849	H
Vermont	050-059	I
Virginia	201, 220-223	E
	224-238, 244	C
	239-243, 245, 246	F
Washington	980-994	E
West Virginia	247-249, 254, 267, 268	F
	250-253, 255-266	D
Wisconsin	530-549	J
Wyoming	820-831	D

Some provisions, benefits, exclusions or limitations listed herein may vary, depending on the jurisdiction. Plans are not yet available in all states. Please check with Direct Benefits for state availability.

SUMMIT SELECT AREA FACTORS

Alabama	All	1
Alaska	All	8
Arizona	All others	2
	850-853	3
Arkansas	All	1
California	All others	4
	900-904	6
	905-916, 926-931	5
	940-944	6
	945-951	5
Colorado	All others	3
	800-804, 808-809	4
Connecticutt	All others	5
	68-69	6
Delaware	All	5
Dist of Columbia	All	5
Florida	All others	3
	330, 332-334, 340	4
	331	5
Georgia	All others	2
	301-302	3
	300,303, 311	4
Hawaii	All	4
Idaho	All others	1
	837	3
Illinois	All others	1
	600-608	4
	610-619	2
Indiana	All others	1
	460-466, 469, 473	2
Iowa	All	2
Kansas	All others	1
	660-661	2
	664-666, 672	2
Kentucky	All	1
Louisiana	All others	1
	700-701	2
	707-712	2
Maine	All	3
Maryland	All others	2
	206-209	4
	210-214	3
Massachusetts	All others	4
	017-019	5
	021-022	6
Michigan	All others	2
	480-485	3
Minnesota	All others	2
	554	4
	550-553, 555	3
Mississippi	All	1
Missouri	All others	1
	630-634, 640-641	2
Montana	All	2
Nebraska	All	1
Nevada	All others	4
	893-898	5
New Hampshire	All	4
New Jersey	All others	4
	070, 074-076	5
	078-079, 088-089	5
New Mexico	All	2
New York	All others	2
	100-102	8
	103-114	5
	115-119	4
	120-129	3
North Carolina	All others	2
	275-277	3
	282	4
North Dakota	All	2
Ohio	All others	1
	430-432, 434-436	2
	439-445	2
	450-452, 456	2
Oklahoma	All others	1
	730-731, 740-741	2
Oregon	All others	3
	970-975	4
Pennsylvania	All others	2
	190-191	4
	189, 192-194	4
Rhode Island	All	3
South Carolina	All	2
South Dakota	All	1
Tennessee	All others	1
	370-372, 380-384	2
Texas	All others	1
	762-764, 768-769	2
	788, 790-799	2
	750-751, 760-761	3
	770, 772-777, 786	3
	787, 789, 752-753	3
Utah	All	3
Vermont	All	3
Virginia	All others	2
	201	5
	220-223	4
	233-237	3
Washington	All others	4
	980-981	6
	982-986	5
West Virginia	All	1
Wisconsin	All others	2
	532-534, 537	3
Wyoming	All	1

MNL DENTAL EXPENSES NOT COVERED/ LIMITATIONS

1) Treatment, services or supplies which:
   A. Are not Medically Necessary;
   B. Are not prescribed by a Dentist;
   C. Are determined to be Experimental Investigational in nature by Us;
   D. Are received without charge or legal obligation to pay;
   E. Would not routinely be paid in the absence of insurance;
   F. Are received from any Family Member;
   G. Are not Covered Procedures.
2) Self-inflicted injuries.
3) War or an act of war, whether or not declared.
4) A Covered Person's commission of a felony or an assault on another person.
5) Riot, nuclear accident, or a major disaster.
6) Employment; whether caused by, related to, or as a condition of employment, including self-employment. This exclusion applies even if Workers' Compensation or any Occupational Disease or similar law does not cover the charges.
7) Treatment which began, before the Covered Person's Effective Date of coverage or after the Covered Person's termination of coverage.
8) Congenital or development malformations existing when the Covered Person's coverage became effective under this Certificate.
9) Cosmetic procedures, unless the coverage is elected by the Policyholder and the required premium is paid.
10) Periodontal splinting.
11) Porcelain on crowns, or pontics posterior to the 2nd bicuspid.
12) Replacement of partial or full dentures, fixed bridge work, crowns, gold restorations and jackets more often than once in any 5 year period.
13) Relining of dentures more often than once in any 2 year period.
14) Lost, stolen, or missing dentures or bridges or for duplicates.
15) Fixed or removable bridgework involving replacement of a natural tooth or teeth which was lost prior to the Covered Person's Effective Date of coverage under this Certificate. Benefits may be payable for bridgework required for loss of teeth while covered under this Certificate, if such bridgework is not an abutment for non-covered bridgework.
16) Prescription Drugs and analgesia pre-medication.
17) Telephone consultations, failure to keep a scheduled appointment, to complete claim forms or attending Dentist statements, and any other services or supplies which are not part of the direct treatment of the Covered Person.
18) Dental education or training programs including oral hygiene or plaque control programs.
19) Counseling on diet and nutrition.
20) Military service, including service in a military reserve unit.
21) Orthodontia, unless this coverage is elected by the Policyholder and the required premium is paid.
22) Prosthodontics, unless this coverage is elected by the Policyholder and the required premium is paid.
23) Charges payable under any medical insurance.
24) Charges made by any government entity unless the Covered Person is required to pay; or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made.
25) Use of materials, other than fluorides or sealants, to prevent tooth decay.
26) Bite registrations.
27) Bacteriologic cultures in connection with a covered dental service.
28) Therapeutic injections administered by a Dentist.
29) Cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling).
30) Replacement of 3rd molars.
31) Composites on teeth posterior to the 2nd bicuspid.
32) Crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.
33) Temporomandibular joint syndrome.

"Your Source for Dental, Disability, Life and Vision Benefits"

DBDEN600

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MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

EMPLOYER GROUP DENTAL APPLICATION

GROUP 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:
_____ Minimum Hours Per Week
☐ All Full Time Employees
☐ Retirees
☐ Other ___________________ Number Eligible ______
Any excluded classes of employees? ☐ Yes ☐ No
If yes, give details ____________________________________

Employee Benefit Waiting Period:

Current Employees: _________________ Day Waiting Period

New Employees: _________________ Day Waiting Period

Effective Date of Coverage / Termination Date of Coverage

Option 1 ☐ 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.

Option 2 ☐ Effective immediately/terminated on the last day for which premium has been paid.

Note: Option 1 always applies to voluntary coverage.

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 PREMIUM / MONTHLY COST

Select one tier structure:

☐ 75% Participation ☐ Voluntary (Select One)

Option A (Summit Select)

☐ Three tier rates: Single: $_______ EE& One Dependent: $________ Family: $_________

Option B (Peak PPO) Administration Fee: $ ______________

☐ Three tier rates: Single: $_______ EE& One Dependent: $________ Family: $_________

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

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

Coverage	EE Dental	Dep Dental
Employee % or Dollar amount		

Note: If the employer pays the entire cost for the employees, then 100% of the eligible employees must apply for coverage.

DENTAL COVERAGE INFORMATION

Employee Plan Option A: Summit Select ☐ 2-9 Employees ☐ 10+ Employees (Select One)

	Benefit Waiting Period	Deductible Amount per Person ☐ Lifetime	Indemnity Coinsurance Percentage
Preventive Care	______________	______________	______________
Diagnostic Care	______________	______________	______________
Basic Care	______________	______________	______________
Major Care	______________	______________	______________
Orthodontics	______________	______________	______________

Dental Maximum (except ortho) Calendar Year ☐ Plan Year ☐ Amount $____________

Endodontics/Periodontics Basic ☐ Major ☐

Orthodontics ☐ Yes ☐ No If Yes, Calendar Year Limit $_____________ Lifetime Maximum $ ___________

Employee Plan Option B: Peak PPO ☐ 2-9 Employees ☐ 10+ Employees (Select One)

	Benefit Waiting Period	Deductible Amount per Person ☐ Lifetime	PPO Coinsurance Percentage In Network/Out of Network
Preventive Care	______________	______________	______________
Diagnostic Care	______________	______________	______________
Basic Care	______________	______________	______________
Major Care	______________	______________	______________
Orthodontics	______________	______________	______________

Office Visit Co-pay: $ _______________

Dental Maximum (except ortho) Calendar Year ☐ Plan Year ☐ Amount $____________

Endodontics/Periodontics Basic ☐ Major ☐

Orthodontics ☐ Yes ☐ No If Yes, Calendar Year Limit $_____________ Lifetime Maximum $ ___________

Dental PPO ☐ Yes ☐ No Network ____

AS THE UNDERSIGNED EMPLOYER:

PREMIUM PAYMENT: I understand and agree that I am responsible for making the proper monthly premium payments. Furthermore, it is understood that a grace period of thirty-one (31) days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the thirty-one (31) day grace period, coverage for all Covered Persons shall lapse as of the premium due date. Any negotiable premium checks received in an envelope postmarked after the thirty-one (31) day grace period will be refunded less any amounts due (if any) from previous months.

MY ANSWERS ARE TRUE AND CORRECT: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my employees. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; or (b) permit me to inaccurately answer any questions. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.

MINIMUM EMPLOYEE/DEPENDENT PARTICIPATION REQUIREMENTS: I also understand that if I am unable to maintain any minimum employee participation under the employer plan, then coverage may cease.

I agree and understand the insurance coverage which is to be placed in force is subject to all of the provisions of the group policy, including, without limitation to the foregoing, the right of the Insurance Company to periodically request and inspect payroll and personnel records which may have a bearing on or be the basis for any insurance coverage requested, placed in force, or maintained.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Dated at: ______________________________ this ________ day of ________________, 20 ________

Signature of Writing Agent	Agent Code	Applicant's Signature	
Signature of Other Agent(s)	Agent Code	Type or Print Applicant's Name	
Agency Name	Agent's Phone Number		
Agent's Business Address	City	State	Zip

SPECIAL REQUESTS

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

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

EMPLOYEE DENTAL INSURANCE APPLICATION

PLEASE PRINT IN SPACE PROVIDED

EMPLOYER INFORMATION		
EMPLOYER NAME	LOCATION	GROUP NO.

EMPLOYEE			
LAST NAME	FIRST NAME		M.I.
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ( )		BIRTH DATE / /

SEX	EMPLOYMENT DATE	MARITAL STATUS	OCCUPATION/TITLE	EMPLOYMENT STATUS
MALE ☐ FEMALE ☐	MM / DD / YY	SINGLE ☐ MARRIED ☐		ACTIVE ☐ INACTIVE ☐

COVERAGE – Check Those That Apply (Note: If declining coverage(s), complete the section REFUSAL/WAIVER only

<u>Dental Insurance</u> Requested Effective Date:___________

☐ EMPLOYEE ☐ SPOUSE ☐ CHILDREN Plan Name Elected:_______________

DEPENDENT INFORMATION			
SPOUSE NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE?______________________
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:
____

REPLACEMENT – IS THIS COVERAGE INTENDED TO REPLACE ANY OTHER DENTAL PLAN? ☐ Yes ☐ No

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE DENTAL COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN
REASON FOR REFUSAL:____

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. To the best of my knowledge and belief, all answers are true and complete.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

DATE	CITY AND STATE
SIGNATURE OF EMPLOYEE	

Verification of Eligibility

Participation requirements are a condition of coverage. These requirements will vary depending upon the plan selected. Please complete this form to verify eligibility. Statements made herein may be used to contest a claim of the validity of any policy issued. If a policy is issued, please see such policy for more information.

1. Employer's name and phone number ____

   Group Number ____________

2. Total number of employees on payroll ____________

3. Total number of employees working 1-29 hours per week (include temporary and/or seasonal employees) ____________

4. Total number of employees in waiting period ____________

5. Number of full-time eligible employees (subtract numbers 3 and 4 from number 2) ____________

If you have purchased an employee paid voluntary group dental product, participation percentages are calculated from the number of full time employees shown in number 5 above. No waivers for coverage under another program will be allowed in this calculation.

For employer paid group coverage (with rates calculated from a census), the number of employees listed in number 6 and 7 below may be subtracted from the number of full time employees shown in number 5 above. Participation requirements will be calculated from that number.

6. Total number of employees enrolled in a DHMO or qualified Discount/Referral plan (proof must be submitted) ____________

7. Total number of employees who are covered under their spouse's plan (an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file) ____________

8. Number of eligible employees (subtract 6 & 7 from 5) ____________

9. Number of full-time employees enrolled ____________

10. Premium information:______100% employer paid **OR** employer pays ______% of employee premium and ______% of dependent premium.

Agreement and Signatures

It is understood and agreed as follows:

1. No coverage is effective until approved by IHC Health Solutions, Inc.
2. Insurance will be effective with regard to those individuals listed in the Eligibility section of the application on the latest of the following dates: a) effective date approved by the company, b) the date the application is signed, or c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the company's right or requirements, or to make or alter any contract or policy.

Dated at:____this_______day of_________________, 200___.

________________________________ Signature of Writing Agent Agent Code	________________________________ Applicant's Signature
________________________________ Type or Print Agent's Name(s)	________________________________ Type or Print Name
________________________________ Agent's Business Address (City, State & Zip Code)	________________________________ Title
________________________________ Agency Agency Code	________________________________ Company Name

AGENT PROCEDURES FOR 2+GROUPS ACH

NEW GROUPS

New 2+ groups can be set up to have monthly bank draft (ACH). **The first business day of the month is the only deduction date available.**

The employer must complete a Bank Authorization form (enclosed) and submit with the initial enrollment of the group. This form can be faxed or e-mailed and an original is not necessary. **IHC HEALTH SOLUTIONS must have this form prior to the effective date of the group.** FYI – The group's bank statement will reflect the name "Specialized Benefits" as the company requesting the withdrawal.

Monthly billing statements will be sent to the group on the 10th of the month prior to the due date. A flyer will be stapled to the billing statement over the remittance address as a reminder. IHC HEALTH SOLUTIONS will request the funds on the first business day of the month for that month's **total premium due**.

EXISTING GROUPS

Any existing 2+ group wanting to begin ACH withdrawals, must be at a "0" balance due in order to begin deductions. This may require that they send IHC HEALTH SOLUTIONS a separate check in order to bring their account to this zero balance. **The first business day of the month is the only deduction date available.**

The employer must complete a Bank Authorization form (enclosed) and submit to IHC HEALTH SOLUTIONS. This form can be faxed or e-mailed and an original is not necessary. **IHC HEALTH SOLUTIONS must receive this form by the 25th of the month prior to beginning the ACH option.** FYI – The group's bank statement will reflect the name "Specialized Benefits" as the company requesting the withdrawal. There is no reduction in billing fees for the ACH option.

Monthly billing statements will be sent to the group on the 10th of the month prior to the due date. A flyer will be stapled to the billing statement over the remittance address as a reminder. IHC HEALTH SOLUTIONS will request the funds on the first business day of the month for that month's **total premium due**.

STOPPING THE ACH DEDUCTION

IHC HEALTH SOLUTIONS must be notified by the 25th of the month in order to discontinue the ACH for the next month.

Please contact IHC Health Solutions, Inc., Administration Department at 800-228-6790 ext 2652 if you have any questions.

BANK AUTHORIZATION

Name of bank: ____
(Include branch name if applicable)

Address of bank/branch: ____

Bank routing number: ________________ Account number: ______________________________

Account type: ☐ Checking (please attach a voided check) ☐ Savings

Print name of bank Depositor: ____

Bank Depositor/Account holder authorization**:**

Depositor hereby authorizes IHC Health Solutions, Inc. ("IHC Health Solutions") to draw checks or make withdrawals by automatic debit each month on this account. Funds will be withdrawn on or about the policy or contract due date. Depositor agrees that the presentation of such check or automatic debit to such bank shall constitute due notice of premium being due upon the said policies or contracts. Depositor agrees that if any withdrawal for the payment of premiums is dishonored, or if the amount has been refunded to the bank upon its request, the payment shall be considered to be in default and if payment of the premium in default is not made within 31 days of the date on which such premium was due, the policy or contract shall terminate except as may otherwise be provided therein.

Depositor agrees that this arrangement may be discontinued by Depositor or IHC Health Solutions for any reason at any time upon written notice to the other. On or after such discontinuance, premiums shall be payable as provided in the policy or contract and at the company's rate for the method of payment selected. I hereby authorize the bank listed above to honor and charge to my account checks drawn or automatic debit entries made on my account by and payable to IHC Health Solutions, Inc. The signatures on such checks may either be typed or printed. The bank shall have no liability for the return unpaid of any such check or automatic debit entry if the balance in my account is insufficient to pay the same upon presentation. I further agree that if any such check or automatic debit entry be dishonored, the bank shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization shall continue in force until revoked by me in writing.

INDEMNIFICATION

In consideration of Bank's participation in the arrangement authorized by Depositor in this document hereof, whereby amounts payable to IHC Health Solutions are collected by checks drawn or automatic debit entries made by the IHC Health Solutions on the account of Depositor, Depositor hereby agrees:

1) IHC Health Solutions will indemnify and hold Bank harmless from any liability to any person or entity having an account with Bank arising out of the payment by Bank of any check drawn or automatic debit entry made by IHC Health Solutions on the account of such person or entity, or arising out of the dishonor by Depositor, whether with or without cause or intentionally or inadvertently, of any such check drawn or automatic debit entry made by IHC Health Solutions whether or not such claim or liability asserted against Bank be based upon the forfeiture or alleged forfeiture of a policy or contract of insurance, the premium on which is sought to be collected by corporate IHC Health Solutions by any such check or automatic debit entry, and

2) IHC Health Solutions will refund to Bank any amount erroneously paid by Bank on any such check or automatic debit entry if claim for the amount of such erroneous payment is made by Bank within twelve months from the date of the check or automatic debit entry on which such erroneous payment was made.

Depositor Date

______________________________________ ____________________
Authorized Signature Title:

NEW BUSINESS CHECKLIST

Please confirm that the following is submitted with all new cases.

- ☐ Completed Employer Application
- ☐ Completed Employee Enrollments
- ☐ First Month Premium (payable to Madison National Life)
- ☐ $15 Monthly Administration Fee (Waived if buying Denali Vision or paying by ACH bank draft.)
- ☐ Producer Licensing Forms (if not previously contracted)
- ☐ VOE Form (required for 75% Participation groups only)

TAKE OVER BENEFIT COVERAGE

Please confirm that all of the following documentation is provided prior to coverage on take over cases:

- ☐ Copy of Prior Carrier's certificate, booklet or schedule of benefits
  (Ortho Takeover - Ortho start dates required)
- ☐ Copy of Prior Carrier's most recent billing statement

After all of the information listed above is completed and signed send all original forms to:

Direct Benefits, Inc.
325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 • 800.620.5010
651.649.3502 fax
info@directbenefits.com

Submission Date:

New Group Information should be postmarked no later than the end of the month to be effective by the first of the following month.