UNITED CONCORDIA

APPLICATION FOR GROUP DENTAL INSURANCE

GROUP'S LEGAL NAME AND ADDRESS:

Name: ______________________ Address: ______________________

____

For general correspondence, receipt of billings and certificates: (If address is different than noted, place contact address on back)

Policymaker Name: ______________________ Title: ______________________

Address: ______________________

Phone #: __________ Fax #: __________ Email: ______________________

Group Administrator: ______________________ Marketing Relationship: ______________________

Phone #: __________ Fax #: __________

PRODUCTS SELECTED: ***Please attach quote/proposal with product and rates marked.***

☑ PPO ☐ DHMO ☐ Indemnity Fee-for-Service

PARTICIPATION SUMMARY:

______# Eligible employees

______# Enrolled

______# Waived

______# Spouse Opt-Outs

GROUP EFFECTIVE DATE:

(1st of month)_____/_____/_____

PRIOR COVERAGE: Yes ☐ No ☐

Carrier ______________________

RATE PERIOD:

(MM/DD/YYYY)

From 03/01/2024 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: ______________________

____

____

______________________.

COVERAGE INCLUDES:

☐ Employee

☐ Spouse

☐ Domestic Partner

☐ Children to Age 19

☐ Children Age 19 to ______

☐ Students only, or

☐ All

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). Application will be returned if quote is not attached. 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. Applicant warrants that all information on this application is true and complete, and acknowledges that coverage may be rescinded if there are material misstatements on this application.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. 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.

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.

Applicant Signature: ______________________ Date: __________

Title: ______________________

Producer: ______________________ UCD Producer ID #: __________

Agency: ______________________ UCD Agency ID #: __________

United Concordia programs are underwritten by the following companies in the listed states:

DENTAL HMO PRODUCTS:

United Concordia Dental Plans of Pennsylvania, Inc.

DENTAL PPO OR INDEMNITY PRODUCTS:

United Concordia Insurance Company