ELITE PROGRAMS, INC

DENTAL INSURANCE APPLICATION - EMPLOYER

UNITED CONCORDIA
America's Premier Dental Insurer®

Group Number: (office use only) _____

Applicant's Legal Name And Address:

Company Name: _____ Today's Date: _____

Contact: _____ Title: _____

Street: _____ City: _____ State: _____ Zip _____

Group Phone: _____ Fax: _____ e-mail: _____

Billing Address (if different than above): _____

Plan Selection:

Desired Effective Date of Coverage: _____ 1st of the month.

Group Size: ☐ Group of 1 ☐ Group of 2+ (employers with 2 or more eligible employees)

Plan Type: ☐ Unlimited ☐ Premier ($5,000) ☐ Enhanced ($2,500) ☐ High ($1,500) ☐ Medium ($1,250)

Rating Region: ☐ Metro (zips 100-199) ☐ Non-Metro (zips 120-139) ☐ Buffalo (zips 140-149)

Rating Structure: ☐ 2-Tier (Ind/Fam) ☐ 4-Tier (E/ES/EC/ESC)

Billing Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

IMPORTANT: The Elite Programs, Inc. dental plan is a prepaid plan. Premiums must be paid prior to the first day of the covered month.

Group Participation:

(Note: Employer groups of 2-4 eligible employees 100% enrollment required. Groups of 5+ Eligible employees 75% enrollment required. Employee waivers due to spousal/other dental coverage count towards eligibility % requirement)

Summary: _____ # of Eligible Employees _____ # of Enrolled _____ # Covered Under Another Plan

Detailed: Number of...	Employees	_____	X	Current Rate: $_____	=	$_____
	Emp/Spouse	_____	X	Current Rate: _____	=	_____
	Emp/1 Child	_____	X	Current Rate: _____	=	_____
	Emp/Children	_____	X	Current Rate: _____	=	_____
	Family	_____	X	Current Rate: _____	=	_____
				TOTAL PREMIUM:		$_____

Eligibility: (groups of 2 or more)

(select one)

New employees are eligible for coverage on the 1st day of the month following ❒ 0 ❒ 30 ❒ 60 ❒ 90 ❒ 180 ❒ 365 days of employment in an eligible class. _____ hours per week defines full-time employment.

Allow Domestic Partner: ❒ Yes ❒ No Allow Late Entrant: ❒ Yes ❒ No

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 the Company. Applicant further acknowledges that no coverage will be effective before the date determined by the Company and only if the first Premium has been paid, and that no agent or broker has the right to accept this application or bind coverage. If this applicant is accepted, it becomes a part of the insurance contract between Applicant and the Company. 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 the Company, it is authorized to amend this application by noting the changes on this form, and the acceptance, evidence 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 premium year.

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 there to, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employer Name: _____

Employer Representative: _____ Title: _____

Signature: _____ Date: _____/_____/_____

No application can be processed without payment, completed and signed applications, and requisite tax documentation.

ELITE PROGRAMS, INC

DENTAL ENROLLMENT FORM - EMPLOYEE

UNITED CONCORDIA
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For New Enrollment, please complete all sections of this from. If you are enrolling for employee-only coverage, you do not need to fill in the Dependent Information section. For Enrollment Changes, please complete the type of Activity and Only the applicable changes along with the employee name and ID number.

General Information:

Group Size:
- ☐ Group of 1 (sole proprietor)
- ☐ Group of 2 or more

Plan Type:
- ☐ Unlimited
- ☐ Premier
- ☐ Enhanced
- ☐ High
- ☐ Medium

Type of Activity:
- ☐ New Enrollment
- ☐ Plan Change (please specify):
  - ☐ Add Dependent
  - ☐ Cancel All Coverage (Enrollee & All Dependents)
  - ☐ Cancel Dependent(s) Only
  - ☐ Change Address
  - ☐ Change of Employee Status (contract change)
  - ☐ Reinstate Coverage (allowed once/12months)
  - ☐ Change Name
  - ☐ Change Provider
  - ☐ Other _____

Group Information:

Group Name: _____ Group Number: _____

Group Administrator/HR Manager/ Group Contact: _____

Employee Information:

ID Number/SS#: _____ Original Employment Date: _____

Employee Name (Last, First, Middle Initial): _____

Home Address: _____ City: _____ St: ____ Zip: _____

Date of Birth: _____ Sex: _____ e-mail:_____

Employee Home Phone: _____ Fax: _____

Dependent Information:

(If dependent children listed below are handicapped or full-time students age 19 or over, please see your group administrator for a dependent certification form, complete and attach the form to this application.)

Social Security #	Type	Last Name	First Name	MI	Sex	Date of Birth
	Spouse					
	Dependent					
	Dependent					
	Dependent					
	Dependent					

I represent that all the information supplied in this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Employee Signature: _____ Date: _____

Employer/Administrator Signature: _____ Date: _____

Employer/ Administrator Phone Number: _____