TDA
Total Dental Administrators

Town & Country Life Insurance Company
709 East South Temple Salt Lake City, Utah 84102

Application for Group Dental Coverage

Application is made to Town & Country 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

a. Type of coverage: ☐ PPO-Indemnity
b. Requested effective date: _____
(Mo.) (Day) (Year)

2. EMPLOYER

a. Full legal name: _____
b. ☐ Corporation ☐ Proprietorship ☐ Partnership
c. Contact Person: _____
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? _____

Return to: **Total Dental Administrators, Inc.**
969 East Murray Holladay Road, Suite 4E Salt Lake City, UT 84117
(801) 268-9873, (800) 880-3536

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 classes 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) _____

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 Town & Country Life Insurance Company. Eligible employees must submit a completed application card to the Employer within 30 days following completion of a _____(0, 30, 60, 90, etc.) day probationary period.

Application for addition of newly acquired eligible dependents through marriage must be submitted to Town & Country 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 CONRIBUTIONS

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

PLAN DESCRIPTION

1. **TERM OF CONTRACT** ☐ One Year ☐ Other (Specify) _____

2. **PLAN OPTIONS**: Choose One ☐ Plan A - Endodontics and Periodontal Services as Class II Benefits
☐ Plan B - Endodontics and Periodontal Services as Class III Benefits
☐ Direct Choice - See Schedule

DEDUCTIBLE:

Per person: ☐ $0 ☐ $25 ☐ $50 ☐ $100 Waived for Class I ☐ Yes ☐ No
Per Family ☐ $0 ☐ $75 ☐ $150 ☐ $300 ☐ NA

MAXIMUM BENEFIT PER YEAR

Per Person ☐ $750 ☐ $1,000 ☐ $1,200 ☐ $1,500 ☐ $2,000
Per Calendar Year for all Covered Dental Benefits - (Class I, II, and Class III)

THE POLICY WILL PAY - "OUT-OF-NETWORK"

Class I: Preventative ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% of the Allowable Fee*
Class II: Basic ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% of the Allowable Fee*
Class III: Major ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% of the Allowable Fee*

Twelve (12) Month Class III Waiting Period Waived? ☐ Yes ☐ No
Credit given for time covered under this employer's prior Plan? ☐ Yes ☐ No

Class IV: Ortho** ☐ Yes ☐ No ☐ 50% ☐ 60% ☐ 70% ☐ 80% of the Allowable fee

Twelve (12) Month Class IV Waiting Period Waived? ☐ Yes ☐ No
Credit given for time covered under this employer's prior Plan? ☐ Yes ☐ No
Adult Ortho Included? ☐ Yes ☐ No

*Payment is based upon the Allowable Fee
** The Orthodontic Lifetime Maximum (if applicable is): ☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000

3. PPO

☐ Yes ☐ No Term of contract: ☐ One Year ☐ Other _____

PPO Payment ("In Network") - Class I _____% Class II _____% Class III _____%

PREMIUMS AGREED TO

Classic Choice

1A. **2 - Tier** ☐ **3 - Tier** ☐ **4 - Tier** ☐

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

Direct Choice

1B. **2 - Tier** ☐ **3 - Tier** ☐ **4 - Tier** ☐

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

2. Initial amount submitted with this Application $ _____
Please attach a copy of the initial Census.

ADDITIONAL INFORMATION

_____

_____

_____

SIGNATURE

1. 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 an approved by the Town & Country Life Insurance Company at its home office; and
c. The initial month's premium is received by Town & Country Life Insurance Company.

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.

2. 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 Town & Country Life Insurance Company to the Employer.

By _____
(print name)

_____
(sign name)

Title _____

Date _____

Witnessed by:

_____
(print agent's name)

By_____
(sign agent's name)

Date _____