CHOICEPLUS Offered by SmileSaver℠

Employer Application
Part 1

1 GENERAL INFORMATION

Company Name: _____

Street: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Nature of Business: _____ SIC Code Number: _____
(General description of products and/or services)

Contact Person: _____ Number of years in business _____

Type of Entity:
- ❑ Sole Owner
- ❑ Partnership
- ❑ Corporation
- ❑ Other

Requested Effective Date: _____ 1st, 200___. I recognize I should not cancel any existing coverage until I am notified of approval as a National Group Trust participant.

2 PLAN SELECTION

1. **Dental HMO** (select one)
   - ❑ Plan 1000
   - ❑ Plan 2000 ❑ Plan 3000 ❑ Plan SM600
   - ❑ Plan 1000-S ❑ Plan 2000-S ❑ Plan 3000-S
   - ❑ Area 1 (Southern CA) ❑ Area 2 (Northern/Central CA)

2. **Fee-For-Service** (select one)
   - ❑ **Indemnity** (❑ Voluntary)
   - ❑ **PPO** (❑ Area Rated ❑ Fixed Fee ❑ Voluntary)

3. **Maximum Fee-For Service Benefits** (select one)
   - ❑ $1,000 ❑ $1,500
   - ❑ $2,000 (N/A for Voluntary Plans)

4. **Preventive**
   - ❑ 100% ❑ 80%

5. **Endodontics/Periodontics Option**
   - ❑ Basic - Covered at 80% (N/A Voluntary PPO)
   - ❑ Major - Covered at 50%

6. **Orthodontia** (automatically included with Dental HMO Plans)
   - ❑ Child Indemnity - All Indemnity/PPO Participants
   - ❑ Dental HMO - Voluntary for Indemnity/PPO Participants

7. **Vision** ❑ Yes for all Dental Enrollees ❑ None
   - ❑ Yes for all Dental HMO Enrollees only
   - ❑ Yes for all PPO/Indemnity Enrollees only

   If yes, select one
   - ❑ Indemnity ❑ SM10 ❑ SM30 ❑ SM20/20 (voluntary)

8. **Probationary Period For New Employees** (select one)
   1st of the month following:
   - ❑ Date of hire ❑ 1 month ❑ 2 months
   - ❑ 3 months ❑ 6 months

9. **Prior Coverage**
   (For non-voluntary groups of 10 or more enrolling employees)
   Does your company have prior group dental coverage?
   ❑ Yes ❑ No If yes, please provide a copy of the prior carrier's bill and benefit booklet.

3 ENROLLMENT CERTIFICATION

1. I certify that all full-time employees including owners are eligible to participate, except the following job classifications: (Please describe, or enter "none") _____

2. Will you offer coverage for domestic partners? ❑ Yes ❑ No

3. I certify that the following personnel data is true and complete:
   - a. Total number of personnel on payroll _____
   - b. Less number of ineligible employees* (-) _____
   - c. Total number of eligible employees (=) _____
   - d. Number of employees with eligible dependents _____
   - * Describe ineligible employees: _____

   e. The employer pays the following portion of the monthly premium:
   Dental HMO (Employer must contribute at least 75% of the "Employee Only" dental HMO prepayment fee.)
   Employee coverage _____% Dependent coverage _____%
   Fee-For-Service (Employer must contribute at least 75% of the Employee only dental HMO premium. N/A for voluntary plans.)
   Employee coverage _____% Dependent coverage _____%

4 SIGNATURE

TO THE TRUSTEE OF THE NATIONAL GROUP TRUST: The undersigned hereby requests the Trustees of the National Group Trust to enroll our firm as a participating employer in said Trust dated the 22nd of September, 1988, as amended, and subscribes and agrees to be bound by the terms and conditions of said Trust. A copy of said Trust will be provided on written request.

The undersigned agrees that the Trustee is merely a holder of the Master Policy, whose only responsibility is to see that certificates are issued to participating employees and to collect premiums, seeking and keeping in force any group insurance policies is an accommodation only. The premium includes a management allowance not to exceed 7%. The insurance agreement and all claims arising thereunder are solely between the undersigned and the insurance carrier.

The undersigned employer-fiduciary understands that the independent agent or broker transacting this business will receive a commission up to 10%, or 20% for the plan SM600, of the premium paid, approves the transaction and acknowledges receipt of a copy of this form.

Date _____ Executed by _____ Title _____
(Owner, Partner, or Corporate Officer)

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Employer Application
Part 2

5 PREMIUM ESTIMATE

1 **RATES**

Dental HMO	DENTAL	VISION	TOTAL		EMPLOYEES		PREMIUM
Employee only	$	$	$	X		=	$
Employee & 1 dependent	$	$	$	X		=	$
Employee & 2+ dependents	$	$	$	X		=	$
						Total Section 1	$

2 **RATES**

Indemnity/PPO	DENTAL	VISION	ORTHO	TOTAL		EMPLOYEES		PREMIUM
Employee only	$	$	$	$	X		=	$
Employee & 1 dependent	$	$	$	$	X		=	$
Employee & 2+ dependents		$	$	$	$		X	= $
							Total Section 2	$
							Total Premium Due (*total of section 1 plus total of section 2*)	$

Please make check payable to "**National Group Trust**"

6 AGENT STATEMENT

Agent Name: _____ Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Email Address: _____

Pay commissions ❑ to me ❑ to my agency Insurance License #: _____

Taxpayer ID#: _____ Is taxpayer a corporation ❑ Yes ❑ No

I am currently appointed by SmileSaver: ❑ Yes ❑ No (If no, please complete licensing forms)

I am currently appointed by Security Life Insurance Company of America: ❑ Yes ❑ No (If no, please complete licensing forms)

Agent Number: SmileSaver: _____ SLIC: _____

I understand I must be appointed before I may receive commission.

Effective date of rate sheet:

I hereby certify that all information contained on this application is correct to the best of my knowledge. I have complied with the underwriting standards, and I have explained the coverage and Plan provisions in detail to the applicant firm. To the best of my knowledge, the firm is a favorable and stable prospect.

Dated _____ Agent Signature _____

GENERAL AGENT NAME AND NUMBER

7 CHECKLIST FOR CASE SUBMISSIONS

❑ 1. Each employee must submit a complete enrollment card, dated and signed.
❑ 2. If the employee is waiving coverage for themselves or their dependents, they must complete the waiver portion of the employee application.
❑ 3. For non-voluntary plans, a current quarter DE6 (Employer's quarterly wage and withholding report) must be submitted with all enrollment material.
❑ 4. Groups submitted after the 20th of the month for the following month effective date must complete the New Group Acknowledgement form.
❑ 5. For non-voluntary groups with 10 or more enrolling employees, please submit a copy of the prior carrier's bill and benefit booklet.
❑ 6. Submit a payment for the first month's coverage plus administrative fee. Please make check payable to "National Group Trust."
❑ 7. Mail enrollment materials to: SmileSaver, File 56748, Los Angeles, CA 90074-6748

Coverage by:
Dental HMO benefits provided by SafeGuard Health Plans, Inc.
Vision HMO benefits provided by SafeGuard Health Plans, Inc.
95 Enterprise, Suite 100, Aliso Viejo, CA 92656-2605
(800) 333-9561 - FAX (800) 798-9021

Indemnity/PPO Dental & Indemnity Vision
Coverage Administered by:
Kelsey National Corporation
3030 South Bundy Dr., Los Angeles, CA 90066
(800) 366-5656 - (310) 390-1000 - FAX (310) 397-2934

Indemnity/PPO Plan Dental and Indemnity Vision are underwritten by Security Life Insurance Company of America, Minnetonka, MN, under Policy GH-893