

APPLICANT'S LEGAL NAME AND ADDRESS: <hr/> Name <hr/> Address <hr/>	For general correspondence, receipt of billings and certificates: (If address is different than noted, place contact address on back) Policymaker Name: _____ Title: _____ Phone: _____ Fax: _____ Email: _____ Group Administrator: _____ Phone: _____ Fax: _____ Email: _____
NATURE OF BUSINESS: _____ INDUSTRY SIC CODE: _____	
Is Applicant exempt from ERISA? Yes <input type="checkbox"/> No <input type="checkbox"/>	

FFS PRODUCTS: **FLEX:** **PREFERRED:** **SELECT:** **CHOICE:** **OTHER:** _____
 STANDARD OPTION: _____

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">IN</td> <td style="text-align: center;">OUT</td> <td style="text-align: center;">STEP PLANS</td> </tr> <tr> <td>Program Deductible: (Ind./Family) \$___/___</td> <td>\$___/___</td> <td>\$___/___</td> </tr> <tr> <td colspan="3">Deductible Max Period: Contract Year <input type="checkbox"/> Calendar Year <input type="checkbox"/> Lifetime <input type="checkbox"/></td> </tr> <tr> <td colspan="3">Deductible Applied to all Services: Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td colspan="3">If No, Services Exempt from Deductible: Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Ortho <input type="checkbox"/></td> </tr> <tr> <td>Program Max: Yr <input type="checkbox"/> Lifetime <input type="checkbox"/></td> <td>\$___</td> <td>\$___</td> </tr> <tr> <td>Ortho Max: Yr <input type="checkbox"/> Lifetime <input type="checkbox"/></td> <td>\$___</td> <td>\$___</td> </tr> <tr> <td colspan="3">Waiting Periods (Mos.): Class I ___ Class II ___ Class III ___ Ortho ___</td> </tr> </table>	IN	OUT	STEP PLANS	Program Deductible: (Ind./Family) \$___/___	\$___/___	\$___/___	Deductible Max Period: Contract Year <input type="checkbox"/> Calendar Year <input type="checkbox"/> Lifetime <input type="checkbox"/>			Deductible Applied to all Services: Yes <input type="checkbox"/> No <input type="checkbox"/>			If No, Services Exempt from Deductible: Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Ortho <input type="checkbox"/>			Program Max: Yr <input type="checkbox"/> Lifetime <input type="checkbox"/>	\$___	\$___	Ortho Max: Yr <input type="checkbox"/> Lifetime <input type="checkbox"/>	\$___	\$___	Waiting Periods (Mos.): Class I ___ Class II ___ Class III ___ Ortho ___			FFS NETWORK REIMBURSEMENT: Advantage <input type="checkbox"/> Advantage Plus <input type="checkbox"/> National FFS <input type="checkbox"/> No Network <input type="checkbox"/> Access <input type="checkbox"/> Pricing -- In ___/Out ___
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		DENTAL PREPAID PRODUCT: PLUS/Third Column: <input type="checkbox"/> Standard Plan _____ Non-Standard Plan: attach detail																							

PREMIUM PAYMENT PERIOD: Monthly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Premium must be paid in advance. Checks payable to United Concordia.	GROUP EFFECTIVE DATE: (1st of month) ___/___/___ <hr/> PRIOR COVERAGE: Yes <input type="checkbox"/> No <input type="checkbox"/> Carrier _____	RATES: Certificate Holder: _____ Certificate Holder & One Adult: _____ Certificate Holder & One Child: _____ Certificate Holder & Children: _____ Certificate Holder & Family: _____
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PARTICIPATION SUMMARY: _____ # Eligible employees _____ # Enrolled _____ # Waived _____ # Spouse Opt-Outs	DEPENDENT COVERAGE INCLUDES: Spouse <input type="checkbox"/> Children <input type="checkbox"/> Non-Students to Age _____ Students to Age _____ Domestic Partners <input type="checkbox"/>	RATE PERIOD: (MM/DD/YYYY) From _____ 12:01 AM (1st of month) To _____ 12:00 AM (Last day of month)
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ELIGIBILITY WAITING PERIOD: New Certificate Holders are eligible for coverage on the ___ of the month following ___ days/mos in an eligible class, or other: _____.

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). 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 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 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. (11 NYCRR Sec. 86.4 (2001) (Reg. 95) and General Counsel Opinion 2-3 2005 (#2)

Applicant: _____ Dated at: _____ (City) _____ (State)
 By: _____ (Date) _____ Producer: _____ SSN#: _____
 Title: _____ Agency: _____ Tax ID: _____
 UC Producer ID#: Agency _____ Producer _____

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

United Concordia Dental Corporation of Alabama - AL
United Concordia Dental Plans, Inc. - MD, NJ
United Concordia Dental Plans of California, Inc. - CA
United Concordia Dental Plans of Delaware, Inc. - DE
United Concordia Dental Plans of Florida, Inc. - FL
United Concordia Dental Plans of Kentucky, Inc. - KY
United Concordia Dental Plans of the Midwest, Inc. - MI,
MO, OH

United Concordia Dental Plans of Pennsylvania, Inc. - PA
United Concordia Dental Plans of Texas, Inc. - TX
United Concordia Insurance Company - AK, AR, AZ, CA, CO, CT, FL, GA, IA, ID, IN, KS
LA, MA, MD, ME, MI, MN, MS, MT, NE, NV, NH, NM, ND, OH, OK, OR, RI, SC, SD, TN,
TX, UT, VT, VA, WA, WI, WV, WY
United Concordia Life and Health Insurance Company - DE, DC, IL, KY, MD, MO, NC, NJ,
PA
United Concordia Insurance Company of New York - NY

Products not available in any state where prohibited by law or where United Concordia does not have regulatory approval.