

Employee Application for Group Dental Insurance

Florida Combined Life

SECTION 1: To be completed by Group Insurance Administrator or Employer

| | | | | | |
|---------------|---|------------|---|----------------------------------|---|
| FCL Group No. | 1 | Group Name | 2 | Business Phone No. () | 3 |
| Division No. | 4 | Class | 5 | Effective Date MM DD YYYY / / | 6 |

SECTION 2: To be completed by Employee (Please print.)

Part A: Complete the following part with information on yourself.

| | | | | | |
|---|----|--|----|--|----|
| Full legal name of employee (Last, First, MI) | 7 | Social Security No. | 8 | Birthdate MM DD YYYY / / | 9 |
| Street Address | 10 | City | 11 | County | 12 |
| | | State | 13 | Zip Code | 14 |
| Home Phone No. () | 15 | Business Phone No. () | 16 | Occupation/Job Title | 17 |
| | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | 18 | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Legally <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated | 19 |
| Full-time hire date MM DD YYYY / / | 20 | Are you <input type="checkbox"/> Actively at work <input type="checkbox"/> Retired <input type="checkbox"/> COBRA | 21 | How paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Salary | 22 |
| | | | | Hours worked per week | 23 |

Part B: Coverage Selection (Note: Consult your group insurance administrator for benefits available to you.)

A Dependent cannot be covered as both a dependent and an employee, covered under more than one employee, in full-time military service, or enrolled for coverages declined by the employee. Married employees of the same employer may not be covered as both an employee and a dependent.

| | | | | | | |
|---|----|---|----|---|----|--|
| Employee <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline coverage | 24 | Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline coverage | 25 | Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline coverage | 26 | <i>If selected, all children must be enrolled. Coverage may continue until the end of the calendar year in which the dependent child reaches age 25.</i> |
|---|----|---|----|---|----|--|

If you checked **YES** in the Employee Coverage selection box, select one of these plans.

| | | | |
|---|--|--|--|
| <input type="checkbox"/> BlueDental Freedom (Indemnity) | | <input type="checkbox"/> BlueDental Choice (PPO) | |
| <input type="checkbox"/> BlueDental Care (Prepaid) | | <input type="checkbox"/> Choice | <input type="checkbox"/> Copayment <input type="checkbox"/> Plus |

Part C: Identify each individual to be covered below. Attach additional sheet of paper, if necessary. Sign and date it.

| | | | | CHECK IF | | | | BlueDental Care PREPAID ONLY | |
|------------------------|------------------------|----------------------|--|------------------|-----------------|---------------|----------|---|--|
| 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 |
| Name (Last, First, MI) | Social Security Number | Birthdate MM/DD/YYYY | Sex | Supported by You | Living With You | FT/PT Student | Disabled | Dental Facility No. (Select from provider list) | Current Patient |
| Employee | N/A | N/A | N/A | N/A | N/A | N/A | N/A | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Spouse | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | N/A | N/A | N/A | N/A | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Child | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Child | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Child | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |

Do any dependents listed above reside at a different address than indicated above? Yes No
If **yes**, list name(s):

Do you or any of your dependents listed above have Dental insurance under another group plan? Yes No
If you answered **yes** to other group dental insurance, complete 40 through 44 below. If more than one dependent, attach a separate sheet of paper with the additional information.

| | | | | | | |
|------------------------------|----|----------------------------------|----|---------------------|-----------|----|
| Dependent Name | 40 | Other Group Plan Name & Plan No. | 41 | Insured/Member Name | Birthdate | 42 |
| | | | | | / / | |
| Insurance Co. Name & Address | | Phone No. () | 43 | Policy No. | | 44 |

| Part D: Coverage Acceptance of ANY Coverage (Please read before signing.) | Part E: Coverage Refusal of ANY/ALL Coverage (Please read before signing.) |
|---|--|
|---|--|

| | |
|---|--|
| I wish to apply for any coverage checked YES under Part B-Coverage Selection. I have read and accept the "Acceptance of Coverage" on the reverse side of this form. I hereby certify that the statements on this application, including any attachment to it, are true and complete. (If you checked NO for any dependent coverage under Part B, sign and date Part E also.) | I do not wish to apply for any coverage checked NO under Part B-Coverage Selection. I understand that if I decide to apply at a later time, coverage will not be available until the next open enrollment. |
|---|--|

| | | | |
|--------------------|------|--------------------|------|
| Employee Signature | Date | Employee Signature | Date |
|--------------------|------|--------------------|------|

Issued by

Florida Combined Life

a subsidiary of



FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Acceptance of Coverage

Please Read Before Signing the Front Side of this Form

I hereby apply for the coverage checked "Yes" on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. if my coverage is to be issued and continued, I must meet all the group contract's requirements; 2. if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any COBRA or ERISA rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

If coordination of benefits applies for me and my dependents and an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that, if I apply for FCL coverage later, coverage will not be available until the next open enrollment.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

A photocopy of this application shall be as valid as the original. However, the original application, labeled "White copy – FCL," is required to evaluate this application. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.