

MASTER APPLICATION FOR EMPLOYEE BENEFITS



AIG Life Insurance Company*

Wilmington, Delaware

A member company of American International Group, Inc.

Administrative Office: 3600 Route 66, P.O. Box 1591, MSN 3D, Neptune, NJ 07754-1591

*This company does not solicit business in New York.

Important Notice

The Company's group underwriting rules will be used to determine whether the applicant, if accepted, will participate in a Trust, or will be issued a group policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim 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.

Applicant Data (A group proposal is required as part of this application)

1. Full Name of Applicant (Company): _____
2. Group Contact Name: _____
3. Street Address: _____
 City: _____ State: _____ Zip: _____ Telephone: (____) _____
 Mailing Address (if different) _____ Fax: (____) _____
 City: _____ State: _____ Zip: _____
 E-Mail Address: _____ SIC Code: _____
4. Applicant is a: Proprietorship Partnership Corporation Union
 Other (Explain): _____
5. Nature of Business: _____
6. Are the employees of any affiliated or subsidiary companies or any other locations to be covered? Yes No
 If yes, give details below. If more space is needed, attach a separate sheet.

Name of Company	Nature of Business	Full Address	# of Full-Time Employees
_____	_____	_____	_____
_____	_____	_____	_____

7. Have you ever applied for, or been insured for, group insurance with any member company of AIG Inc., including United States Life? Yes No
 If yes, give details: Group Policy Number(s) _____
 Date Insurance Ended/Declined _____ Effective Date (if still insured) _____
8. Please complete the information below for those coverages being replaced:

Current Coverage Employer	Voluntary	Replacing with the Company's Plans?*	Prior Plan Name & Effective Date	Proposed Termination Date
Life** <input type="checkbox"/>	Life** <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Dental <input type="checkbox"/>	Dental <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Vision <input type="checkbox"/>	Vision <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
STD <input type="checkbox"/>	STD <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
LTD <input type="checkbox"/>	LTD <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).
 ** Are there other Group Life Insurance plans in force which you are not replacing or currently applying for with another carrier? Yes No If yes, please indicate the highest benefit amount of each plan.

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the Company plan may not take effect until the day after the existing insurance is terminated.

For Home Office Use Only	Group Number: _____	Division Number: _____
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Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least * 30 hours (20 hours for Voluntary Life only) per week, or _____ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.

9. Do you want to exclude any classes of full-time employees from coverage? Yes No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** _____

Total # of excluded employees _____

* Amount of hours may vary by state law.

Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

10. Waiting Period: Present Employees _____ months OR First of the month following _____ months*
 Future Employees _____ months OR First of the month following _____ months*

*Only option available for Voluntary Coverages. Available on Group coverages with the 1st of the month effective date only.

11. a. Number of Full-Time Employees (Include employees not to be covered and those being continued) _____

b. Number of Full-Time Employees **waiving all coverages** _____

12. Do you employ 20 or more employees? (Include part-time, union, etc.) Yes No

Contribution Data – Not applicable to Voluntary Coverages

13. Will the employees be required to contribute toward the cost of the insurance? Yes No

If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.

Coverage	LifelAD&D	Dep Life	EE Dental*	Dep Dental*	EE Vision*	Dep Vision*	STD	LTD
Employer %								

*The employer must contribute a minimum of 35% of the total dental and vision premiums.

14. Premiums will be paid: Annually Semi-annually Quarterly Monthly EFT

Employee/Dependent Data

15. Are there any employees who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? Yes No

If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. **NOTE: This question does not need to be answered for Life and AD&D groups with more than 50 employees insured, Dental coverages, for Disability coverages with ten (10) or more employees insured, or for EXACT replacement coverage for 2-50 Life and AD&D and 2-9 Disability.**

Name of Employee	Date Disability Began	Current Amount of Group Life Insurance In Force	Describe Nature of Injury/Sickness	Date Return To Full-Time Work

Requested Effective Date

I request that the coverage(s) chosen take effect on:

- the date the application is approved in writing by the Company; or
 _____ If the application is approved in writing by the Company, this will be the Effective Date, which may not be changed.

For Employer Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included. For Voluntary Plans, the effective date must be the first of the month.

Applicant's Declaration

- I verify that all employees applying for coverage listed on the census form are actively at work and working at least *30 hours per week, unless another minimum work requirement was authorized by the Company, and all employees meet the eligibility requirements as listed on the application.
- I verify that the Company's benefit plan(s) have been offered to all employees. Completed waivers are attached for those employees and dependents electing not to participate in the plan(s). Note: Changes in the Census data may affect previously quoted rates.
- To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
- The agent(s) appointed for this application is (are): _____.
- I understand that this application may be an application to participate in a Trust, as determined by the underwriting rules of the Company. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund.
A copy of the Trust Policy will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Policy.
- I understand and agree that:
 - no agent may change or waive any of the provisions of this application or of any plan of insurance;
 - any change or waiver may be made only by an officer of the Company; and
 - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
 - If the insurance contract compromises a part of an employee benefit plan, the Company is granted **sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.
- It is understood and agreed that the group employer will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, and that the Company may rely on this information in adjudicating any claim under the policy.

DATE _____ PRINT NAME OF OFFICER, PARTNER, PROPRIETOR _____

WITNESS _____ SIGNATURE OF OFFICER, PARTNER, OR PROPRIETOR _____

* Amount of hours may vary by state law

** May not be applicable in all states, and may vary by state law.

The Policyholder/Participant Employer hereby agrees to accept certificates in electronic format for delivery to persons covered under a group policy issued by the Company.

Note: If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.

Producing Agent's Declaration

Please Print

PRODUCING AGENT

Producer #	Tax ID # / SS #	% Commissions split with other agents
Name As Licensed		License #
Mailing Address		
City/State/Zip		
Phone	Fax	E-Mail
Signature	Date	City and State Where Signed

Please Print

GENERAL AGENT

General Agent #	Name	Tax ID # / SS #
Phone	Fax	E-Mail

HOME OFFICE USE ONLY

Policy No.	Premium Deposit \$	Underwriter
Mode	Coverages	
Group Contact	Producer	GA

Census Information (This form may be photocopied if additional supply is needed) – Not applicable for Voluntary Coverages.

For H.O. Use Only Class/Div.	Employee's Soc. Security#	Name (Last, First, MI)	Sex M/F	City/State of Residence	Current Salary***	Date of Birth		Occupation/ Title*	Date of Hire		Marital Status**	# of Dependents	Coverage Election			Coverage Selected			
						M	D		M	D			E - Employee	S - Spouse, C - Child	Life	LTD	STD	INT.	Dental
1.	-																		
2.	-																		
3.	-																		
4.	-																		
5.	-																		
6.	-																		
7.	-																		
8.	-																		
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13.	-																		
14.	-																		
15.	-																		
16.	-																		
17.	-																		
18.	-																		
19.	-																		
20.	-																		

*Please indicate state or federal coverage continuation here. Mark column with "C" along with date continuation began.

**Marital Status Codes: S-Single, M-Married, W-Widowed, D-Divorced

***Please state if salary is per hour, per week, per month or per year.

For H.O. only:
Group Number: _____

DEPENDENTS' INFORMATION AND BENEFICIARY DESIGNATION FORM

This form may be used only in conjunction with a Group Enrollment Census form for initial enrollment. This form is not an employee application and should not be used for the addition of new employees.

Employee Information To be completed by each employee

Employee's Name: _____
LAST FIRST MI
Name of Employer: _____
Group #: _____ Social Security # _____

Dependent Information for Life Coverage

To insure your dependents, please complete the following: (Employee is the beneficiary for all insured dependents)
Spouse's Name* _____ Birthdate ____/____/____
LAST FIRST MI
Social Security No. _____ Male Female *A notarized affidavit is required for Domestic Partners.
Applicant's Signature: _____ Date: _____

Beneficiary Designation

If applying for Life Coverage, enter the Beneficiary information.
Beneficiary Name: _____ Relationship _____
LAST FIRST MI
Contingent Beneficiary: _____ Relationship _____
LAST FIRST MI
Applicant's Signature: _____ Date: _____

REFUSAL OF COVERAGE

Employee Information (Please Print)

Employee's Name: _____
LAST FIRST MI
Name of Employer: _____
I was given the opportunity to enroll in this plan for group insurance offered by my employer. I am refusing: _____
 LTD Dental Vision
 STD Employee & Dependents Employee & Dependents
 Life/AD&D Spouse Spouse
 Dependent Life Child(ren) Child(ren)
 Supplemental Life/AD&D All Dependents All Dependents
 All Coverages Offered

MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:

Are you or your dependents now covered by another group plan? YES NO
(Your dependent(s) may be insured by this plan even if they are insured elsewhere.)

If Yes: Policyholder's Name _____ Carrier _____

I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of other applicable insurance plan. If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage. I must furnish, at my expense, evidence of insurability satisfactory to the carrier if I wish to enroll in any other coverage that is now being refused.

_____/_____/_____
DATE OF REFUSAL _____
APPLICANT'S SIGNATURE

Life/AD&D

Group Name _____

- Waiver of Premium included
- Reduction Formula: Life Insurance and AD&D insurance reduce by 35% at age 65 and 50% at age 70.
- For 2-9, AD&D insurance terminates at age 70.
- BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay or other special compensation such as commissions.

INSURANCE SCHEDULE

- Life and AD&D insurance will be written subject to the published maximum guidelines.

<i>Class of Employees</i> List by salary, job title, union membership or other employment conditions.	<i>Life / AD&D Schedule</i>	<i>Life / AD&D Amounts Subject to EOI</i>	<i>Total Amount Requested Per Life AD&D</i>
1.			
2.			
3.			
4.			
5.			

CHANGE IN AMOUNT OF INSURANCE: A change in the amount of Life and AD&D insurance will take effect on:

the date of change other _____

ISSUE Trust True Group

BENEFIT OPTIONS - See Proposal

DEPENDENT LIFE INSURANCE Yes No

Amounts: Spouse/Child \$10,000/2,000 \$5,000/1,000 Domestic Partners included

ADDITIONAL OPTIONS

- Not all options are available for 2-9
- Check all that apply Work and Family Benefits Upgrade AD&D - Tier One
- BTA Supplemental Life (Indicate Schedule Below) Upgrade AD&D - Tier Two
- Life only/No AD&D Without Waiver of Premium Critical Illness
- Dependent Life Insurance Selections:
 - legal spouse of employee children to _____ years, _____ if student
 - Amount: Spouse \$ _____ Children \$ _____
- Reduction Formula: Please specify if different from above.
 - Life _____
 - AD&D _____
- Special Requests: _____
- _____
- _____
- _____
- _____

Disability

Group Name _____

- Is the business run from the home? Yes No How long has business been in existence? _____ years
- Are there any employees who do **not** participate in Social Security or Worker's Compensation? Yes No

If yes, explain _____

Issue Trust True Group

LONG TERM DISABILITY BENEFITS

2-9 Lives

Elimination Period 90 or 180 days
 Benefit per Month of Disability _____% of Basic Monthly Pay, up to a maximum of \$_____

(\$1,000 to \$6,000 in \$1,000 increments)

Integration Family

Regular Occupation Period 2 Years

Minimum Benefit of gross monthly benefit The greater of \$100 or 10% GMB

Maternity as any other sickness Yes

Pre-Existing Conditions Limit 3/12 (or as mandated by state)

Survivor Benefit 3X monthly report

Mental, Nervous, Drug & Alcohol Limitation 24 Months

Benefit Duration Age 65 ADEAI

Partial Deefinition Proportionate Loss

Conversion Option Not available
 COLA Not available

10+ lives

_____ days
 _____% of Basic Monthly Pay, up to a maximum of \$_____

Family Primary 70% All Sources

1 Year 2 Years 3 Years 5 Years Unlimited

\$_____

Yes

3/12 Other _____

3X 6X

24 Months See Quote

Age 65 ADEAI 5 Year RBD NSSRA 2 year RBD

Proportionate Loss Dollar for Dollar 50% Offset

Yes No

Yes No _____% _____ Adjustments

SHORT TERM BENEFITS

2-9 Lives

Benefit per Week of Disability _____% of Basic Weekly Pay, not to exceed \$_____

Flat Amount

\$_____ Not to exceed 60% of Basic Weekly Pay

Elimination Period Waived if Hospitalized Not available

Elimination Period _____ days for injury
 _____ days for sickness

Maximum Weeks per Disability 13 26 Weeks

Maternity as any other sickness Yes No

Pre-Existing Conditions Limit 3/12 Standard
 12/12 w/Maternity

Minimum Benefit \$25/week

10+ lives

_____% of Basic Weekly Pay, not to exceed \$_____

Flat Amount \$_____ Not to exceed 60% of Basic Weekly Pay

Yes No

_____ days for injury
 _____ days for sickness

_____ Weeks

Yes No

No 3/12 3/6/12

\$25/week

INTEGRATED DISABILITY BENEFITS

100+ lives

Integrated Disability Management Billing Yes American General No Other _____
 USL
 AIG
 AIN

Special Requests _____

Dental and Vision

For H.O. use only: Group Number: _____
 Division Number: _____

Group Name _____ Employee Only Employee and Dependents
 Issue Trust True Group

Reasonable and Customary Plans:

2-9 lives

	Deductible	Coinsurance	Deductible Waived for Preventive	Annual Maximum
<input type="checkbox"/> Plan 1	\$50	100%/80%/50%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500
<input type="checkbox"/> Plan 2	\$100	100%/80%/50%	No	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500
<input type="checkbox"/> Plan 3	\$50	100%/80%/0%	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$1,000

10+ lives

Annual Deductible: \$ _____ Family Limit: 3X 2X
 Lifetime None
 Coinsurance: Preventive _____ %
 Basic _____ %
 Major _____ %
 Annual Maximum: \$1000 \$1500 or \$2000
 Enhanced Benefits Package Yes No
 Deductible waived for preventive: Yes No
 All dental waiting periods waived Yes No
 Supplemental Accident Yes No

Orthodontia: Yes; Lifetime Deductible: \$0 No
 50% Coinsurance
 Lifetime Maximum: \$1000
 Other _____
 Adult (Age 19+) Orthodontia: Yes No
 NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child-only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

Point-of-Service PPO Plans:

MAC (Maximum Allowable Charge) – 2-9 lives 10 or more lives

Annual Deductible: \$ _____ Lifetime
 * Deductible waived for preventive (out of network) IN OUT
 Coinsurance: * Preventive _____ / 100%
 Basic _____ / 80%
 Major _____ / 50%
 Annual Maximum: \$ _____ / \$ _____
 Waiting periods waived
 Orthodontia: Yes, Lifetime Deductible: \$0 No
 Coinsurance: _____ %
 Lifetime Maximum: \$1000 Other _____
 Adult Orthodontia: Yes No (Age 19+)

Networks Available:
 (Check network applicable to your area)
 AIG National Dental Network
 Delta Dental of New Jersey

Family Limit: 3x 2x None
 Enhanced Benefits Package: Yes No
 Supplemental Accident: Yes No
 Sealants: Yes Age _____ No

NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child-only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

R & C (Reasonable & Customary) – 2-9 lives 10 or more lives

Annual Deductible: \$ _____ Lifetime
 Deductible waived for preventive (out of network) IN OUT
 Coinsurance: Preventive _____ / _____
 Basic _____ / _____
 Major _____ / _____
 Annual Maximum: \$ _____ / \$ _____
 Waiting periods waived
 Orthodontia: Yes, Lifetime Deductible: \$0 No
 Coinsurance: 50%
 Lifetime Maximum: \$1000 Other _____
 Adult Orthodontia: Yes No (Age 19+)

Networks Available:
 (Check network applicable to your area)
 AIG National Dental Network
 Delta Dental of New Jersey Premier

Family Limit: 3x 2x None
 Enhanced Benefits Package: Yes No
 Supplemental Accident: Yes No
 Sealants: Yes Age _____ No
 HIAA 90th percentage out of network

NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child-only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

Scheduled Plan:

- Reimbursement Dental Plan (Available 5+ lives)
Annual Deductible: \$0 \$25 \$50 \$100
Conversion Factor (\$10-\$20): \$ _____
Annual Maximum: \$500 \$750 \$1000 \$1500 (10+ lives only)
Preventive dentistry covered at 100% of Reasonable and Customary with deductible waived: Yes No
Orthodontia: Yes; Lifetime Deductible \$50 No
50% Coinsurance
Lifetime Maximum: \$1000

NOTE: Orthodontia is available only to groups of 10 or more lives and is paid at Reasonable and Customary.

Voluntary Plan:

- Voluntary Dental (Discount Dental Service Plan) - Careington Network

DHMO Dual Option Programs (Nationwide):

- Informal Dual Option/ Indemnity (Available 10+ lives. Group Indemnity plan sold alongside another Company's prepaid plan.)
- | | |
|--|--|
| <input type="checkbox"/> Plan I
\$50 annual deductible - Coinsurance: | <input type="checkbox"/> Plan II
\$50 annual deductible - Coinsurance: |
| Preventive 100% | Preventive 80% |
| Basic 80% | Basic 80% |
| Major 50% | Major 50% |
| Annual Maximum: <input type="checkbox"/> \$1000 <input type="checkbox"/> \$ 1500 | Annual Maximum: <input type="checkbox"/> \$1000 <input type="checkbox"/> \$ 1500 |
| Deductible waived for preventive: <input type="checkbox"/> Yes <input type="checkbox"/> No | Annual Enrollment Period _____ |
- Informal Dual Option/PPO Dental (Available 10+ lives in specific areas. Consult your agent for information. Group PPO Plan sold alongside another company's prepaid plan. MAC plans only.)
- | | |
|--|---------------------------------|
| Annual Deductible: \$50 - Coinsurance: | In and out; MAC |
| Preventive 100% | |
| Basic 80% | |
| Major 50% | |
| Annual Maximum: <input type="checkbox"/> \$1000 <input type="checkbox"/> \$ 1500 | Annual Enrollment Period: _____ |

Vision Insurance:

- See proposal for benefits **Issue** Trust True Group
One exam covered annually
Lenses and Contacts covered annually
 Plan A, Annual Frames Frequency
 Plan B, Biennial Frames Frequency

- Special Requests for Dental and/or Vision

Voluntary Coverages

1. Correspondent's full name and address: (If different than indicated on page 1) _____

NOTE: Person named above is required to communicate individual coverage status to the employee.

2. Number of payroll deductions per year _____

3. Annual Enrollment/Solicitation dates _____ to _____

4. Individual Age bracket changes and increase in amounts of insurance will take effect:

- Plan Anniversary First of the month following the change

LIFE INSURANCE: Yes No

BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay or other special compensation such as commissions.

2-199 LIVES

- A. Premium rate schedule:
 Unismoke **OR** Smoker/Non-smoker
- B. Waiver of premium: standard, terminates at age 65
- C. Requested benefit schedule: standard
Employee: \$10,000 to \$300,000 available in \$10,000 increments, not to exceed 5X the employee's basic annual salary.
Spouse: \$10,000 to \$200,000 available in \$5,000 increments, not to exceed 5X the employee's basic annual salary.
Children: \$5,000

200+ LIVES

- A. Premium rate schedule:
 Unismoke **OR** Smoker/Non-smoker
- B. Waiver of premium (if proposed) Yes No
- C. Requested benefit schedule:
Employee: _____
Spouse: _____
Children: _____
Please advise if any of the above are excluded.

\$300,000 maximum available to groups with 10-199 eligible lives.

Please note: Completing medical questions is not necessary for guarantee issue coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D): Yes No

BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay or other special compensation such as commissions.

2-199 LIVES

- A. Requested benefit schedule: standard
Employee: \$10,000 to \$300,000, available in \$10,000 increments, not to exceed 5X the employee's basic annual salary.
Spouse: \$10,000 to \$200,000, available in \$5,000 increments, not to exceed 5X the employee's basic annual salary.

200+ LIVES

- A. Requested benefit schedule:
Employee: _____
Spouse: _____

* \$300,000 maximum available to groups with 10-199 eligible lives.

LONG-TERM DISABILITY: Yes No

- A. Industry classification (2-199 eligible lives only): _____ (Proposal must be included)
- B. \$100 increments available? Yes No
- C. Benefit Percentage: 40% 50% 60%
- D. Benefit Maximum \$6,000 Other: _____
- E. Benefit Duration: Age 65 "ADEA I" (after age 65)
- F. Elimination Period: 30 days 60 days 90 days 180 days

A copy of the final group proposal must be included for groups of 200 eligible lives or more.

Special Requests: _____

SHORT-TERM DISABILITY: Yes No

- A. Female Percentage (2-199 eligible lives only) _____ (Proposal must be included)
- B. \$10 increments available? Yes No
- C. Benefit Percentage: 40% 50% 60%
- D. Benefit Maximum \$500 \$1,000 (for select industries) Other: _____
- E. Benefit Duration: 13 weeks 26 weeks
- F. Elimination Period: 0 days injury/7 days sickness 7 days injury or sickness 14 days injury or sickness
 29 days injury or sickness 7 days injury / 14 days sickness
- G. Pre-existing conditions limitations: 3/12 12/12 with maternity

A copy of the final group proposal must be included for groups of 200 eligible lives or more.

Special Requests: _____

Voluntary Coverages (cont'd)

Discount Dental Plan (Careington Network)

OR

Indemnity Plan [minimum 25 eligible employees with 10 enrolled] **OR** Point-of-Service PPO Plan
Annual Deductible \$50 **OR** \$100 Lifetime Waived for Preventive
Annual Maximum (Non-Orthodontic) benefit: \$1000 per insured person or \$1500 per insured person

Coinsurance

Indemnity: 100/80/50 100/50/50

PPO: 100/80/50 in & out 100/50/50 in & out

Out of Network: MAC R & C

Orthodontia Yes: Adult/Child Yes: Child-only No
\$0 deductible, 50% to \$1,000 lifetime maximum

\$300 Supplemental Accident Endo / Perio in Basic

Reduced Premium Option

VISION (minimum 10 eligible employees with 5 enrolled): Yes No

In-Network Copay – \$10 Exam / \$20 Lenses

One Exam covered annually

Lenses and Contacts covered annually

Plan A, Annual Frames Frequency

Plan B, Biennial Frames Frequency

Special Requests: _____

