



# Dental Cents<sup>®</sup>

**A COMMON SENSE  
DENTAL PLAN  
FOR GROUPS OF  
2 THROUGH 9  
EMPLOYEES**

# Dental Cents Benefits

Dental “Cents” is fully insured by Companion Life Insurance Company and offers groups with two to nine employees the choice of four plans. No other coverage is required and [you and your employees have your choice of Dentists](#).

Covered Services	Dental Cents Plans			
	Plan A	Plan B	Plan C	Plan D
<b>Class I Preventive Services</b>				
Routine Exams and cleanings (two per 12 months)				
Fluoride treatment for children under age 16 (one per 12 months)				
Bitewing X-Rays (one per 12 months)	100%	100%	100%	100%
X-rays (full mouth or panorex, one per 60 months)				
X-rays of the roots of teeth				
<b>Class II Basic Services</b>				
Simple restorative services (fillings)				
Simple tooth removal	80%	80%	N/A	80%
Emergency treatment for dental pain (minor procedures)				
Sealants for children ages 6 through 15 (one per tooth per 36 months)				
Space Maintainers for children under age 16				
<b>Class III Major Services</b>				
Endodontics (includes root canals)				
Periodontics				
Major restorative services (crowns and inlays)				
Prosthodontics (bridges and dentures)	50%	50%	N/A	50%
Surgical tooth removal and other oral surgery				
Medically appropriate anesthesia related to a covered surgery				
Denture relines (if over six months after installation)				
Recementation and repair of crowns, inlays, bridges and dentures				
<b>Class IV Orthodontia Services (Optional)</b>				
No deductible, children under age 19 only	50%	50%	N/A	50%
Separate Lifetime Maximum	\$1,000	\$1,000	N/A	\$1,000
Waiting Period	12 Months	12 Months	N/A	12 months
<b>Coinsurance/Plan Provisions</b>				
Contract Year Maximum per person	\$1,000	\$1,000	\$1,000	\$1,000
Lifetime Deductible per person, applies to all covered services except orthodontia	\$100	N/A	N/A	N/A
Preventive services deductible per person per contract year	N/A	\$25 Preventive	N/A	N/A
Basic and major services deductible per person per contract year	N/A	\$50 Basic and Major	N/A	\$50 Basic and Major
Copay per visit	N/A	N/A	\$15	N/A
Waiting Period on major services	12 months	12 months	N/A	12 months

## Takeover Benefits (If requirements below are met)

Takeover means that we give employees credit for waiting periods they have accumulated for similar coverages under your current group dental plan. For Takeover consideration the following are required:

- Evidence that your current carrier’s coverage has been in force for at least 12 months prior to the effective date of your Companion Life Dental plan.
- A copy of your most recent bill that includes a listing of all covered employees with their effective dates noted.
- A copy of the inforce dental plan (contract, certificate or booklet).

## Dental Eligibility Guidelines

**Firms:** Sole proprietorships, partnerships or corporations with at least two full-time employees, including active, full-time owners or partners, are eligible.

**Employees:** All active, full-time employees working at least 30 hours per week, including active, full-time owners or partners are eligible. Those employed on the date the firm becomes insured with Companion Life are eligible on that date. New employees hired after that date are eligible upon completion of the waiting period selected by the employer.

**Dependents:** Eligible dependents include the insured employee's spouse and unmarried children prior to their 25th birthday who do not work for the firm.

**Non-standard and Ineligible Industries:** Some industries are not eligible under this program, and others require special rating consideration. Refer to the rate information insert to this brochure for details, or contact Companion Life directly for more information.

Companion Life reserves the right to reject any business or industry which does not, in our opinion, represent a sound underwriting risk.

## Participation Requirements

**Employee Participation:** The Dental "Cents" insurance plans are designed for businesses with 2-9 employees, and must be offered to all eligible employees of the business (see definition of "eligible employees" under Dental Eligibility Guidelines above). It is not acceptable to "carve out" or split off a specific class of employee to be insured. **For employer groups of 2-5 employees, all employees must be insured under the program. For employer groups of 6-9 employees, all employees less one must be insured under the program.**

Firms that fall below minimum employee participation will have **90 days** to bring the participation to the required level. If less than the required number of employees are insured after 90 days, the firm's coverage will be terminated.

No individual who is eligible for coverage as an employee can be insured as a dependent. If two eligible employees are married, both must be covered as employees, with only one insuring eligible children.

**Dependent Participation:** There is no participation requirement for dependents.

**Employer Contribution:** The employer must contribute a minimum of 25% of the cost of employee dental insurance for all covered employees.

## My Insurance Companion

**What is My Insurance Companion?** An innovative Web-based technology designed especially for Companion Life Dental Providers and Members. It's free. It's secure.

**Members may use My Insurance Companion** to check claims status, verify eligibility, request an ID card, view Explanation of Benefits (EOB), receive pre-treatment estimate status and ask customer service.

**Dental Professionals may use My Insurance Companion** to enter claims online, verify patient eligibility, check claims status, check the status of services rendered using the graphical tooth display and view dental pre-estimate and orthodontic letters.



## Miscellaneous Benefits

### Predetermination of Benefits:

As a service to protect the insured, Companion Life will provide predetermination of benefits for recommended treatment plans that exceed \$300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. This benefit helps insureds better understand their coverage. The insured should submit the treatment plan to Companion Life for review and predetermination of benefits before the service begins.

### Coordination of Benefits:

Employees and their dependents should not make a profit from being insured under more than one group insurance policy. To prevent this from happening, most group insurance policies include a coordination of benefits provision. The coordination of benefits provision under this plan allows for coordination of benefits with any other group payments. When all benefits are added together, no more than 100 percent of the covered expenses will be paid.

### Companion Life Dental Plan

**Changes:** Should an employer switch from one Companion Life plan to another, employees will be given credit for waiting periods accumulated.

### RATES ARE GUARANTEED FOR 12 MONTHS.

Payment is based upon allowable charges in the area in which the service is rendered.

# Limitations

## We will not pay benefits for the following non-covered expenses.

1. Any treatment for cosmetic purposes or to correct congenital malformations, except for medically necessary care and treatment of congenital cleft lip and palate.
2. Any expense incurred or procedure begun before your current period of continuous coverage, unless takeover benefits apply.
3. Any expense incurred or procedure begun after your insurance under this section terminates, except under Plans A, B and D for a prosthetic appliance, fixed bridge, crown, or inlay or onlay restoration for which both (a) the procedure begins before insurance ends and (b) the item's final placement is within 90 days after insurance ends.
4. Education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
5. Broken appointments or the completion of claim forms.
6. Any Basic and Major services under Plan C.
7. Harmful-habit appliance therapy.
8. Orthodontics or any services associated with orthodontic therapy under Plan C or under Plans A, B and D when this optional coverage is not elected and the premium is not paid. In any event, orthodontia covered charges will not include charges:
  - a. incurred by employee or spouse;
  - b. incurred by dependent children age 19 or over;
  - c. for any services payable under any other provisions of the policy; or
  - d. for any services in the first 12 months the Insured is covered under this policy.
9. Sealants which are:
  - a. not applied to a permanent molar.;
  - b. applied before age 6 or after attaining age 16; or
  - c. reapplied to a molar within three years from the date of a previous sealant application.
10. Any injury arising out of, or in the course of, work for wage or profit.
11. Any injury or condition for which you are eligible for benefits under any Workers' Compensation act or similar laws.
12. Charges for which you are not liable or which would have not been made had no insurance been in force.
13. Services not recommended by a dentist, not required for necessary care and treatment, or do not have a reasonably favorable prognosis.
14. Conditions as a result of war or any act of war, declared or not, or while on full-time active duty in the armed forces of any country.
15. Payment to you if payment is not legal where you are living when you incur the expenses.
16. Procedures for which benefits are payable under the employer's medical expense benefits plan for employees and their dependents.
17. Services or supplies a family member or a member of your household provides.
18. Major services under Plans A, B and D in the first 12 months that you or your dependents are covered, except as may be provided in the takeover benefits provision.
19. Replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge under Plans A, B and D within five years of the date of the last placement of these items. This does not include those you may need because of an accidental bodily injury you received while you had this insurance. We will not cover replacement if the item can be repaired.
20. Initial placement of any prosthetic appliance or fixed bridge, under Plans A, B and D unless for replacement of natural teeth pulled during the same period of continuous coverage. The removal of a third molar (wisdom tooth), however, does not qualify the appliance or bridge for payment. Any such appliance or fixed bridge must include the replacement of the pulled tooth or teeth. Coverage does not include paying for the replacement of teeth pulled before you had this coverage.
21. Addition of teeth to an existing prosthetic appliance or fixed bridge under Plans A, B and D unless for replacement of natural teeth pulled during the same period of continuous coverage. The removal of a third molar (wisdom tooth) does not qualify the appliance or bridge for payment.
22. Duplication of appliances or replacement of lost or stolen appliances.
23. Appliances, restorations or procedures to:
  - a. alter vertical dimension;
  - b. restore or maintain occlusion;
  - c. splint or replace tooth structure lost as a result of abrasions or attrition; or
  - d. treat jaw fractures or disturbances of the temporo- mandibular joint.
24. Subgingival curettage or root planing (procedure numbers 4220 and 4341), unless the presence of periodontal disease is confirmed by both X-rays and pocket depth summaries of each tooth involved.
25. Any services related to equilibration, bite registration or bite analysis.
26. Crowns for the purpose of periodontal splinting.
27. For charges for any implants, overdentures and associated precision or semi-precision attachments and any related endodontic treatment associated with it; or other customized attachments.
28. Charges for myofunctional therapy, orthognathic surgery or athletic mouthguards.

Some Products Not Available In All States

COMPANION®



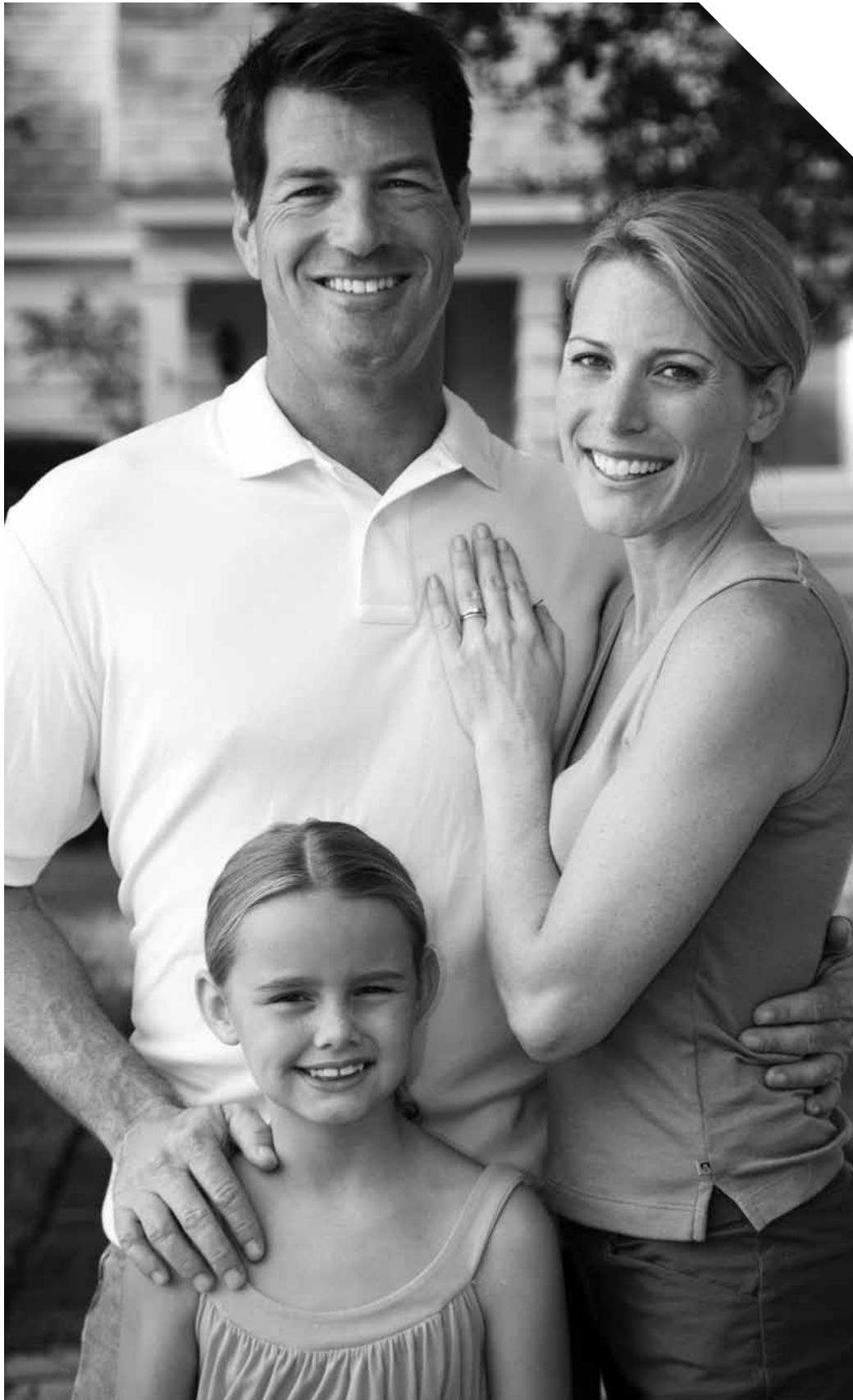
**P.O. Box 100102**

**Columbia, SC 29202-3102**

**800-753-0404**

**E-mail: [c.life@companiongroup.com](mailto:c.life@companiongroup.com)**

**[www.CompanionLife.com](http://www.CompanionLife.com)**



**Rate  
Information**

# Dental Cents<sup>®</sup>

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DENTAL PLAN  
FOR GROUPS OF  
2 THROUGH 9  
EMPLOYEES**

# Standard Industry Code (SIC) Factors

FACTOR IS 1.00 IF SIC CODE IS NOT SHOWN BELOW

## Industry Discount

	<b>SIC Code</b>	<b>Discount</b>	<b>SIC Factor</b>
Agriculture	0100-0999	-15%	.85
Mining	1000-1499	-15%	.85
Construction	1500-1999	-15%	.85
Manufacturing	2000-3999	-10%	.90
Transportation	4000-4299	-10%	.90
	4400-4499	-10%	.90
Pipeline	4600-4699	-10%	.90
Transport Services	4700-4799	-10%	.90
Utilities	4900-4999	-10%	.90

## Industry Surcharge

	<b>SIC Code</b>	<b>Surcharge</b>	<b>SIC Factor</b>
Banking, Investments	6000-6299	+10%	1.10
Insurance	6300-6499	+10%	1.10
Real Estate	6500-6699	+10%	1.10
Holding Companies	6700-6999	+10%	1.10
Amusement Companies	7800-7999	+10%	1.10
Health Services	8000-8049	+15%	1.15
	8070-8099	+15%	1.15
Legal Services	8100-8199	+15%	1.15
Miscellaneous Services/Organizations	8300-8999	+15%	1.15
Public Administration	9000-9999	+15%	1.15
Education	8200-8299	+25%	1.25

Dentists and Dental Labs (SIC 8021, 8072) Ineligible For Dental Coverage

Companion Life reserves the right to decline to propose benefits for any business or industry which does not, in our opinion, represent a sound underwriting risk.

# Base Rates

Rates Are Guaranteed For 12 Months.

Effective November 1, 2008

PLAN A Monthly Base Rate													
Dental Cents - Plan A - Nov 2008 - Mar 2009													
\$100 Lifetime Deductible, 100/80/50, 12 month waiting period on Class III Procedures, \$1,000 Max													
	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L	Area M
Employee	\$22.90	\$24.10	\$25.31	\$26.79	\$28.28	\$29.76	\$31.26	\$33.03	\$34.83	\$36.91	\$38.70	\$41.08	\$43.15
Employee + 1	\$43.52	\$45.79	\$48.10	\$50.91	\$53.72	\$56.54	\$59.40	\$62.77	\$66.17	\$70.13	\$73.53	\$78.06	\$81.98
Employee + 2+	\$68.48	\$72.06	\$75.69	\$80.12	\$84.54	\$88.97	\$93.47	\$98.77	\$104.13	\$110.36	\$115.71	\$122.84	\$129.01
PLAN B Monthly Base Rate													
Dental Cents - Plan B - Nov 2008 - Mar 2009													
\$25 Preventive and \$50 Basic & Major Contract Year Deductibles, 100/80/50, 12 month waiting period on Class III Procedures, \$1,000 Max													
	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L	Area M
Employee	\$22.45	\$23.62	\$24.81	\$26.26	\$27.71	\$29.16	\$30.64	\$32.37	\$34.13	\$36.17	\$37.92	\$40.26	\$42.29
Employee + 1	\$42.65	\$44.88	\$47.14	\$49.89	\$52.65	\$55.40	\$58.21	\$61.51	\$64.84	\$68.72	\$72.06	\$76.50	\$80.34
Employee + 2+	\$67.11	\$70.62	\$74.18	\$78.51	\$82.85	\$87.19	\$91.60	\$96.80	\$102.05	\$108.15	\$113.39	\$120.38	\$126.43
PLAN C Monthly Base Rate													
Dental Cents - Plan C - Nov 2008 - Mar 2009													
\$15 Copay per Visit, 100/0/0, \$1,000 Max													
	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L	Area M
Employee	\$10.15	\$10.68	\$11.22	\$11.87	\$12.53	\$13.18	\$13.85	\$14.64	\$15.43	\$16.35	\$17.15	\$18.20	\$19.12
Employee + 1	\$19.28	\$20.29	\$21.31	\$22.56	\$23.80	\$25.05	\$26.32	\$27.81	\$29.32	\$31.07	\$32.58	\$34.58	\$36.32
Employee + 2+	\$36.35	\$38.25	\$40.17	\$42.52	\$44.87	\$47.22	\$49.61	\$52.43	\$55.27	\$58.57	\$61.41	\$65.20	\$68.48
PLAN D Monthly Base Rate													
Dental Cents - Plan D - Jan 2009 - Mar 2009													
\$50 Contract Year Deductible, 100/80/50, 12 month waiting period on Class III Procedures, \$1,000 Max													
	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L	Area M
Employee	\$25.60	\$26.93	\$28.29	\$29.94	\$31.60	\$33.25	\$34.94	\$36.92	\$38.92	\$41.25	\$43.25	\$45.91	\$48.22
Employee + 1	\$48.63	\$51.17	\$53.75	\$56.89	\$60.04	\$63.18	\$66.38	\$70.14	\$73.94	\$78.37	\$82.17	\$87.23	\$91.62
Employee + 2+	\$76.53	\$80.53	\$84.58	\$89.53	\$94.48	\$99.42	\$104.46	\$110.38	\$116.36	\$123.32	\$129.31	\$137.27	\$144.17

See Dental "Cents" brochure (95067) for information on policy benefits and limitations.

Orthodontia (optional – available only with Plans A, B and D) – Monthly Base Rate \$4.65 (All Areas)

Add to all dependent rates – Employee plus 1, Employee plus 2 plus

## Quarterly Adjustment Factor

April 2009 - June 2009 1.02    July 2009 - September 2009 1.03    October 2009 - December 2009 1.05  
Applied to Base Rates Above

## Rate Formula

Using Rates For    PLAN A     PLAN B     PLAN C     PLAN D

Proposed Effective Date \_\_\_\_\_ Area \_\_\_\_\_

	Monthly Rate	Quarterly Adjustment Factor	SIC Factor	Orthodontia Rate (Optional for Plans A, B and D)	Number Enrolling	Cost
Employee Only	\$ _____	x _____	x _____	N/A	x _____	= \$ _____
Employee +1	\$ _____	x _____	x _____	+ _____	x _____	= \$ _____
Employee +2+	\$ _____	x _____	x _____	+ _____	x _____	= \$ _____
				Monthly Administration Fee	+	\$ 15.00
				Total Cost		\$ _____

# Area Table

(By First 3 Digits of ZIP Code)

<b>Alabama</b>	C	<b>Kansas</b>		<b>Mississippi</b>		<b>Pennsylvania</b>	
<b>Arkansas</b>	C	661-662	D	392	D	190-192	I
<b>Delaware</b>		660, 672	C	All Others	C	189, 193-194	H
197, 198	I	664-668	B	<b>Missouri</b>		180-181	F
All Others	D	All Others	A	640-641, 649	E	150-152, 176, 179	E
<b>District of Columbia</b>	M	<b>Kentucky</b>		631	D	182-183, 186-188	E
<b>Florida</b>		402, 405-406, 410	D	630, 633	C	195-196	E
330-332, 340	L	All Others	C	658	B	153-157, 159	D
333-335, 337	J	<b>Louisiana</b>		All Others	A	164-166, 168	D
341	I	701	G	<b>Montana</b>		170-175, 184-185	D
329, 336, 339	H	700, 704, 707-708	E	591, 598	E	All Others	C
342, 346, 349	H	All Others	D	All Others	D	<b>Rhode Island</b>	H
320, 322, 326-328	G	<b>Maine</b>		<b>Nebraska</b>	A	<b>South Dakota</b>	C
338, 344, 347	G	040-041	H	<b>Nevada</b>		<b>Tennessee</b>	
All Others	F	042, 044-046, 048	G	F		372	D
<b>Georgia</b>		All Others	F	<b>New Hampshire</b>		All Others	C
303, 311, 399	G	<b>Maryland</b>		030-031, 033	I	<b>Texas</b>	
300	F	208-209	L	All Others	H	752-753, 770-772	G
301, 302	E	207	K	<b>North Carolina</b>		750-751	F
305-306, 308-309	C	206	I	276, 282	F	733, 760-761, 786-787	E
307, 310, 312-314	B	212	H	271, 277	E	762-763, 773-775	D
316-319, 398	B	210-211, 214, 219	G	270, 272-275	D	790-792	C
All Others	A	215, 217	F	280-281, 286-289	D	All Others	B
<b>Idaho</b>		All Others	E	All Others	C	<b>Vermont</b>	G
833, 835-838	D	<b>Massachusetts</b>		<b>North Dakota</b>	C	<b>Virginia</b>	
All Others	C	021-022	K	<b>Ohio</b>		201, 220-223	J
<b>Illinois</b>		016-018, 024-026, 055	J	441-443, 452	F	224-225, 233-237	G
600, 602, 606-608	J	013-015, 019-020	I	430-432, 436, 440	E	226-232, 238, 244	F
601, 603	I	023, 027	I	434-435, 444-445, 447	D	240-241	D
604-605	H	010-011	H	450-451, 454, 456	D	All Others	C
610-611, 627	E	All Others	G	All Others	C	<b>Washington</b>	
609, 613-618, 623	D	<b>Michigan</b>		<b>Oklahoma</b>		980-981	L
All Others	C	480	J	730-731, 740-741	E	985-986, 990-992	K
<b>Indiana</b>		481-483	I	All Others	D	All Others	J
462	F	484-485	G	<b>Oregon</b>		<b>West Virginia</b>	C
463-466	E	488-489	F	972	J	<b>Wisconsin</b>	
460-461, 467-469	D	486-487, 490-492	E	970-971	I	532, 534, 537, 543	G
473, 479	D	All Others	D	974-979	H	549	F
All Others	C	<b>Minnesota</b>		All Others	G	530-531, 539, 547	E
<b>Iowa</b>		550, 551, 553-555	G	<b>Wyoming</b>		All Others	D
500-503, 509	D	556-564	F				
All Others	C	All Others	D				

# How To Enroll

- 1 Arrive at final rates for the group by:
  - A. Determining the group's **rate area**, **quarterly adjustment factor** and **SIC factor** using charts included;
  - B. Then, determining the monthly **base rates** for the group's desired plan on the enclosed Rate Sheet and completing the Rate Formula at the bottom of the Rate Sheet.
- 2 Complete the Employer Participation Application. If Takeover from a previous dental carrier, please submit:
  - A. A copy of your previous insurance carrier's most recent billing statement;
  - B. A certificate or letter of acceptance from your previous insurance carrier that shows the effective date of your policy; and
  - C. A copy of your previous insurance carrier's certificate, booklet or schedule of benefits.
- 3 Have an Employee Enrollment Card completed by each full-time employee.
- 4 Have the group's check for one month's premium payable to: **Companion Life Insurance Company**.
- 5 Mail Rate Calculation, Employer Participation Application, Employee Enrollment Cards and the check to:

**Group Marketing  
Companion Life Insurance Company  
P.O. Box 100102  
Columbia, SC 29202-3102**

If you have any questions, please call **1-800-753-0404** and ask for **Group Marketing**.



P.O. Box 100102  
Columbia, SC 29202-3102

(800) 753-0404    FAX (800) 836-5433

E-mail: [c.life@companiongroup.com](mailto:c.life@companiongroup.com)

[www.CompanionLife.com](http://www.CompanionLife.com)



P.O. Box 100102, Columbia, SC 29202

DENTAL EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

EMPLOYER (APPLICANT) INFORMATION (Please Print or Type)

Legal Name of Employer \_\_\_\_\_

Type of Business (Sole Proprietorship, Partnership, Corporation, etc.) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Contact \_\_\_\_\_ Title \_\_\_\_\_ (Person to contact concerning coverages)

No. of Eligible Employees : \_\_\_\_\_ No. of Eligible Employees Enrolled: \_\_\_\_\_

Effective Date Requested: \_\_\_\_\_ SIC Code and Nature of Business: \_\_\_\_\_ (The firm's effective date will be the first or the 15th of the month following written acceptance by Companion Life Insurance Company.)

How many years in this business? \_\_\_\_\_ How many years at this location? \_\_\_\_\_

Tax I.D. Number: \_\_\_\_\_ No. of Family Members in Organization: \_\_\_\_\_

PLAN DESCRIPTION

PLAN REQUESTED:

- Plan A: I - 100% II - 80% III - 50% - \$1,000 Annual Maximum - \$100 Lifetime Deductible
Plan B: I - 100% II - 80% III - 50% - \$1,000 Annual Maximum - \$25/\$50 deductible
Plan C: I - 100% II - N/A III - N/A - \$1,000 Annual Maximum - \$15 copay per visit
Plan D: I - 100% II - 80% III - 50% - \$1,000 Annual Maximum - \$50 Contract Year Deductible

Are Orthodontia Benefits requested? (Plans A, B and D only) [ ] Yes [ ] No

Are Takeover Benefits requested? [ ] Yes [ ] No If yes, please provide the following:

a. Name of Prior Carrier: \_\_\_\_\_

b. Effective Date of Prior Plan: \_\_\_\_\_ c. Termination Date of Prior Plan: \_\_\_\_\_

Also, submit a copy of your previous insurance carrier's most recent billing statement as well as a certificate or letter of acceptance that shows the effective date of your policy along with a copy of your previous carrier's certificate, booklet or schedule of benefits. If prior carrier's bill does not include the effective date of each employee's coverage, please note this information next to each employee's name so we can give the correct credit for transfer of benefits.

Employment Waiting Period: [ ] 1 Month [ ] Other: \_\_\_\_\_ (No waiting period applies to those employed on the effective date.)

Coverage following the completion of the waiting period selected will be effective on the first or the 15th of the month only.

The employer agrees to contribute the following percentage of the cost of employee dental insurance for all covered employees \_\_\_\_\_% (25% required)

FRAUD WARNING: (Not Applicable in AZ, FL, MD, OR, VA): 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 (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING: (FL only): 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.

Participation Agreement (Administered and underwritten by Companion Life Insurance Company)

The Participant hereby applies for Group Insurance Benefits as set forth in the above "Dental Employer Participation Application for the Joint Employer Group Insurance Trust" and subscribes to the Agreement and Declaration of Trust.

Name of Trust: The Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does the Trustee have any obligation under any policy of insurance and that all claims for and benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy(ies). The Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666.

(Signature of Employer/Applicant)

(Title) (Date)

This is to certify that I, the undersigned agent, have truly and accurately recorded on this application form the information supplied.

(Signature of Agent/Broker) (Date)

Print Agent/Broker's Name License No.

FOR HOME OFFICE USE

Accepted by Administrator Effective: \_\_\_\_\_

By: \_\_\_\_\_

(Title) (Date)