MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
P. O. BOX 20593, INDIANAPOLIS, IN 46220

EMPLOYER GROUP DENTAL APPLICATION

GROUP INFORMATION

Legal Name of Employer:			
Applicant's Phone Number:	Federal Tax ID No.		
Nature of Business:	SIC Code:		
Billing Address:	City:	State:	Zip Code:
Street Address (if different from above):	City:	State:	Zip Code:
Name of Subsidiaries, Divisions. Locations or Affiliates to be Covered:			
Name and Title of Employer Plan Administrator/Human Resources Contact:	Phone Number: ( )	Fax Number: ( )	
Proposed Effective Date of Insurance:			
Advance payment of $_____ is submitted herewith to be applied by the Company to premiums for insurance when and if issued.			

ELIGIBILITY

Eligible Classes:
_____ Minimum Hours Per Week
☐ All Full Time Employees
☐ Retirees
☐ Other_____ Number Eligible _____
Any excluded classes of employees? ☐ Yes ☐ No
If yes, give details_____

Employee Benefit Waiting Period:

Current Employees: _____ Day Waiting Period

New Employees: _____ Day Waiting Period

Effective Date of Coverage / Termination Date of Coverage

Option 1 ☐ Effective the first day of the month coincident with or next following the date the Employee Benefit Waiting Period is completed and application is approved/terminated on the last day for which premium has been paid.

Option 2 ☐ Effective immediately/terminated on the last day for which premium has been paid.

Note: Option 1 always applies to voluntary coverage.

PRIOR CARRIER INFORMATION

If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, give the carrier, the type of coverage and the date the insurance was or is to be discontinued.

_____ _____
Carrier Name Termination Date

For Credit for Prior Coverage to be considered, this application must be accompanied by a current month's billing from the current carrier, a copy of an in-force certificate and benefit schedule as well as proof of the effective date for each insured individual and dependents, if insured.

DENTAL PREMIUM / MONTHLY COST

Select one tier structure:

☐ Composite rate: $_____

☐ Two tier rates: Single: $_____ Family: $_____

☐ Three tier rates: Single: $_____ EE& One Dependent: $_____ Family: $_____

☐ Four tier rates: Single $_____ EE&Spouse $_____ EE/Child(ren): $_____ Family: $_____

☐ Five tier rates: Single: $_____ EE&Spouse: $_____ EE& 1 Child: $_____ EE&Children: $_____ Family: $_____

☐ Five tier rates: Single $_____ EE&Spouse $_____ EE& 1 Child $_____ EE&2 or 3 deps $_____ EE&4or more deps $_____

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 employee will pay.

Coverage	EE Dental	Dep Dental
Employee % or Dollar amount		

Note: If the employer pays the entire cost for the **employees**, then 100% of the eligible employees **must** apply for coverage.

DENTAL COVERAGE INFORMATION

Employee Plan Option A: _____

	Benefit Waiting Period	**Deductible Amount per Person** (check one) ☐ Annual ☐ Lifetime	**Select One** ☐ **Indemnity Coinsurance** Percentage	☐ **PPO Coinsurance Percentage** In Network/Out of Network
Preventive Care	_____	_____	_____	_____
Diagnostic Care	_____	_____	_____	_____
Basic Care	_____	_____	_____	_____
Major Care	_____	_____	_____	_____
Orthodontics	_____	_____	_____	_____

Office Visit Co-pay: $_____

Other Co-pays $_____ Applied to: _____

Dental Maximum (except ortho) Calendar Year ☐ Plan Year ☐ Amount _____

Orthodontics ☐ Yes ☐ No If Yes, Calendar Year Limit $_____Lifetime Maximum $_____

Dental PPO ☐ Yes ☐ No Network _____

Optional Benefits (additional premium may be required)

Deductible credit/Annual maximum credit (only available on calendar year plans): ☐ Yes

Posterior Composites (this box needs to be checked and additional premium paid to add this coverage) ☐ Yes

Posterior Porcelain Crowns (this box needs to be checked and additional premium paid to add this coverage) ☐ Yes

Coverage for Veneers (this box needs to be checked and additional premium paid to add this coverage) ☐ Yes

AS THE UNDERSIGNED EMPLOYER:

PREMIUM PAYMENT: I understand and agree that I am responsible for making the proper monthly premium payments. Furthermore, it is understood that a grace period of thirty-one (31) days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the thirty-one (31) day grace period, coverage for all Covered Persons shall lapse as of the premium due date. Any negotiable premium checks received in an envelope postmarked after the thirty-one (31) day grace period will be refunded less any amounts due (if any) from previous months.

MY ANSWERS ARE TRUE AND CORRECT: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my employees. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; or (b) permit me to inaccurately answer any questions. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.

MINIMUM EMPLOYEE/DEPENDENT PARTICIPATION REQUIREMENTS: I also understand that if I am unable to maintain any minimum employee participation under the employer plan, then coverage may cease.

I agree and understand the insurance coverage which is to be placed in force is subject to all of the provisions of the group policy, including, without limitation to the foregoing, the right of the Insurance Company to periodically request and inspect payroll and personnel records which may have a bearing on or be the basis for any insurance coverage requested, placed in force, or maintained.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Dated at:_____ this_____ day of _____, 20___

Signature of Writing Agent	Agent Code	Applicant's Signature
Signature of Other Agent(s)	Agent Code	Type or Print Applicant's Name
Agency Name		Agent's Phone Number
Agent's Business Address	City	State / Zip

SPECIAL REQUESTS

Send Administration Kit, Certificates, and ID Cards to: □ Broker □ Employer

Verification of Eligibility

Participation requirements are a condition of coverage. These requirements will vary depending upon the plan selected. Please complete this form to verify eligibility. Statements made herein may be used to contest a claim of the validity of any policy issued. If a policy is issued, please see such policy for more information.

1. Employer's name and phone number _____
   Group Number _____
2. Total number of employees on payroll _____
3. Total number of employees working 1-29 hours per week _____
   (include temporary and/or seasonal employees)
4. Total number of employees in waiting period _____
5. Number of full-time eligible employees _____
   (subtract numbers 3 and 4 from number 2)

If you have purchased an employee paid voluntary group dental product, participation percentages are calculated from the number of full time employees shown in number 5 above. No waivers for coverage under another program will be allowed in this calculation.

For employer paid group coverage (with rates calculated from a census), the number of employees listed in number 6 and 7 below may be subtracted from the number of full time employees shown in number 5 above. Participation requirements will be calculated from that number.

6. Total number of employees enrolled in a DHMO or qualified Discount/Referral plan _____
   (proof must be submitted)
7. Total number of employees who are covered under their spouse's plan _____
   (an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file)
8. Number of eligible employees (subtract 6 & 7 from 5) _____
9. Number of full-time employees enrolled _____
10. Premium information:_____100% employer paid **OR** employer pays _____% of employee premium and _____% of dependent premium.

Agreement and Signatures

It is understood and agreed as follows:

1. No coverage is effective until approved by GroupLink, Inc.
2. Insurance will be effective with regard to those individuals listed in the Eligibility section of the application on the latest of the following dates: a) effective date approved by the company, b) the date the application is signed, or c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the company's right or requirements, or to make or alter any contract or policy.
4. The employer applicant agrees to notify GroupLink of any changes to the above numbers representing a change of five percent or more and the employer further agrees to provide GroupLink with payroll records verifying number of employees upon request by GroupLink.
5. The employer applicant agrees and understands that if the contributory status or participation percentages change that GroupLink reserves the right to adjust the premiums and rates accordingly.

Dated at:_____this_____day of_____, 200__.

Signature of Writing Agent Agent Code	Applicant's Signature
Type or Print Agent's Name(s)	Type or Print Name
Agent's Business Address (City, State & Zip Code)	Title
Agency Agency Code	Company Name

GroupLink, Inc.
Independence Holding Group

NEW BUSINESS SUBMISSION FORM

Policy Administration Information

The following information needs to be completed in order to assist GroupLink in administering your dental plan. Please place a check mark in the appropriate box or circle where indicated.

Employer Name: _____ Phone Number: _____

Employer E-mail Address: _____

Agent E-mail Address: _____

INITIAL ENROLLMENT PROCESS

***Employer wishes to submit initial enrollments as follows (check one)*:**

____ Online enrollment via the Internet (GroupLink will advise password).
____ Download and forward data from Employer's database on disk/tape or E-mail to GroupLink (circle one).
____ Submit hardcopy enrollments to ***GroupLink*** or ***Agent*** (circle one) (GroupLink provide forms).

ONGOING ENROLLMENT PROCESS

***Employer wishes to submit ongoing enrollments as follows (check one)*:**

____ Online enrollment via the Internet (GroupLink will advise password).
____ Download and forward data from Employer's database on diskette/tape or E-mail to GroupLink (circle one).
____ Submit hardcopy enrollments to ***GroupLink*** or ***Agent*** (circle one) (GroupLink provide forms).

ADMINISTRATION KITS (WELCOME TO GROUPLINK)

***GroupLink to forward the Administration Kit and Instruction Guide as follows (check or circle as indicated)*:**

____ Send via the Internet to Agent or Employer (circle one).
(*above information will be E-mailed within 5-7 business days of receipt of completed requirements*)
____ Send hardcopy directly to ***Agent*** or ***Employer*** (circle one).

DENTAL INSURANCE POLICY AND CERTIFICATES

***GroupLink to forward the Policy and Certificates as follows (check or circle as indicated)*:**

____ Send via the Internet to Agent or Employer (circle one).
(*above information will be E-mailed within 5 - 15 working days of receipt of all completed requirements*)
____ Send hardcopy directly to ***Agent*** or ***Employer*** (circle one).

Note: Based on Insurance Regulations, it is required that the Employer provide the Insurance Certificates to the Employees either as a hardcopy or through online access.

The undersigned acknowledges the above instructions and understands the importance of providing the Employees the Insurance Certificates immediately upon receipt.

_____ _____
Employer's Signature Date

GroupLink, Inc.
Independence Holding Group

MADISON NATIONAL LIFE INSURANCE COMPANY, INC. – P.O. Box 20593, Indianapolis, IN

EMPLOYEE DENTAL, LIFE, VISION, & WEEKLY DISABILITY INCOME INSURANCE APPLICATION

PLEASE PRINT IN SPACE PROVIDED

EMPLOYER INFORMATION		
EMPLOYER NAME	LOCATION	GROUP NO.

EMPLOYEE			
LAST NAME	FIRST NAME		M.I.
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ( )		BIRTH DATE / /

SEX MALE ☐ FEMALE ☐	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE ☐ MARRIED ☐	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE ☐ INACTIVE ☐

COVERAGE – Check Those That Apply (Note: If declining coverage(s), complete the section REFUSAL/WAIVER only

Dental Insurance

☐ EMPLOYEE ☐ SPOUSE ☐ CHILDREN REQUESTED EFFECTIVE DATE:_____

DEPENDENT INFORMATION			
SPOUSE NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) □ Yes □ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) □ Yes □ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) □ Yes □ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) □ Yes □ No

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE?_____
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:
_____

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE DENTAL COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN
REASON FOR REFUSAL:_____

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

DATE	CITY AND STATE

SIGNATURE OF EMPLOYEE