EMPLOYER ELECTION FORM

If accepted, the undersigned Employer agrees: (a) To make such benefits available to all present employees and all employees becoming eligible in the future; and (b) To make payroll deductions as required for the plan as are applicable to the employees. The undersigned Employer further agrees that only those full-time employees who meet the *eligibility requirements (as defined under Eligibility within the brochure) are to be included, and that participation requirements must be met before the benefit plan can be made effective. The employer agrees that not less than five (5) non-related employees of the employer's eligible employees must be enrolled in the Dental Plan to prevent cancellation of coverage. To be eligible for the Employer Paid premium rates illustrated, the employer agrees to contribute no less than 75% of the employee only premium or 50% of the combined employee/dependent premiums.

The undersigned Employer requests that benefits be made available to all employees subject to the following conditions:

a) No coverage for any employees shall take effect until this Agreement and the employee's individual Enrollment Cards are accepted by the Company and the initial premium paid; and

b) Employer agrees to remit regularly, in advance, the required premium payments to the Administrator and acknowledges and agrees that this Plan is established under and is subject to the provision of the Employee Retirement Income Security Act (ERISA), as amended. The undersigned Employer is the Plan Administrator as defined in ERISA, as amended.

EMPLOYER INFORMATION

Name of Employer: _____ Send Correspondence to: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Fax: (_____) _____

Nature of Business: _____ ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other

Subsidiaries and Affiliates Included: ☐ Yes ☐ No

Name and Address of Subsidiaries & Affiliates whose employees are to be covered: _____

_____

Effective Date Requested:
_____ (limited to 1st or 15th of the month)

INITIAL PROBATIONARY PERIOD
(a) For current employees - NONE
(b) For future employees: _____ DAYS/MONTHS
New hires to be effective on the first of the Month following probationary period

PLAN SELECTION (not available in SD)

DENTAL ADOPTION AND PARTICIPATION AGREEMENT

☐ Samaritan Dental Plan A (100/80/50-100/80/50) ☐ Samaritan Dental Plan B (100/90/60-100/80/50)

☐ Option 1 - $1,000 ☐ Option 2 - $1500 ☐ Option 3 - $2,000 ☐ Add Child Orthodontia (to age 19)

☐ Employer Funded

PARTICIPATION AND CONTRIBUTIONS

The undersigned Employer agrees to contribute:
EMPLOYEE: $ _____/OR_____% EMPLOYEE/+ ONE: $ _____/OR_____%

EMPLOYEE/CHILD(REN):$ _____/OR_____% EMPLOYEE/FAMILY: $ _____/OR_____%

There are initially _____ full-time employees of which _____ are enrolled in this Plan.

CURRENT DENTAL PLAN
Is this group currently enrolled under another group dental program? ☒ Yes ☐ No

Are CPT Benefits requested? ☒ Yes ☐ No

Did you include a copy of the current Plan and a copy of the last billing? ☐ Yes ☐ No

The undersigned Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under Group Dental Policy GH-1112-40420 insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

Authorized Signature_____

Date _____ E-Mail _____

PRODUCER'S STATEMENT – I hereby certify that all the information contained in this Employer Election Form is correct to the best of my knowledge and I know nothing unfavorable about this entity or any individual proposed for participation. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the entity.

Producer Name _____ SS#/TIN#_____ Appointed with Security Life? ☐ Yes ☐ No

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____ Signature _____

Group Enrollment: Return completed form to your employer

FOR COMPANY USE ONLY
Effective Date: _____/_____/_____
Plan Code: _____
Group # / Division _____
CPT: _____
SLIC

Employer Information (TO BE COMPLETED BY THE EMPLOYER)

Name and Address of Employer or Organization (if applicable)	Full-Time Hire Date
	Telephone Number

Employee Information (PLEASE PRINT CLEARLY)

Coverage Election: ☐ Dental Only

I apply for coverage on: ☐ Employee Only ☐ Employee + Spouse ☐ Employee & Child(ren) ☐ Employee & Family

Last Name	First Name	Initial	Birth Date MM/DD/YYYY / /
Address	Telephone Number		Sex: ☐ Male ☐ Female
City	State / Zip		Marital Status ☐ Married ☐ Single

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Plus One					/ /
Dependent					/ /
Dependent					/ /
Dependent					/ /

Please note: If additional dependent information is necessary please attach a separate sheet of paper.

Does Spouse have a dental plan: Yes ☐ No ☐ With whom?_____
If answer is "Yes", are dependents enrolled under spouses plan? Yes ☐ No ☐

Group Dental Coverage is provided under the Group Dental Insurance Policy GH-1112 issued to the Employers' Voluntary Benefit Insurance Trust insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

Group Vision Coverage is provided under the Group Vision Policy GH-1157 or under the Group Vision Policy GH-1154 issued to the Group Policyholder (policyholder may be a trustee group policyholder in some states) insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

By my signature below, I hereby apply for the coverage or coverage's selected above. I certify that I have read the applicable Fraud Notice below. I also hereby authorize payroll deductions from my earnings for any contributions required. This Authorization remains in effect until revoked by me in writing.

California Law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

_____ _____
Employee Signature Date