

FOR PUBLIC RELEASE

dental by design

A COMPLETE DENTAL INSURANCE PORTFOLIO

FROM COMPANION LIFE.



dental by design

Considering dental insurance for groups with 10 or more employees?

What features and benefits are important to you?

flexible options.

versatile plan designs.

reasonable premiums.

Have it all with Companion Life!

Companion Life recognizes that dental insurance needs can vary by group, industry and region. Employers are looking for benefit programs that are unique and flexible. We took a close look at these dental insurance needs and went “to the drawing board” to create exceptional and practical Group Dental Insurance plans for employer groups of 10 or more.

You asked for affordable, progressive dental insurance solutions. We listened. Your objectives and your needs are our inspiration. **Dental by Design**SM plans are developed with maximum flexibility in mind — for you and your employee groups!

TAILOR OUR PLAN TO YOUR NEEDS

Realize the power of distinct design with unique and exceptional plan flexibility from Companion Life.

We’re *confident* that you’ll find a plan that suits your needs! How can we be so sure? You may customize any of our standard **Dental by Design** benefit plans — Dental Essentials, Dental Choice or Dental Select — to include the options that are just right for your group.

A wide choice of options is available to modify these program features. Options like **deductible, number of deductibles per family, incentive plan, waiting periods, contract year maximum, increasing maximum, orthodontia benefits (adult available), exams and X-rays, frequency of cleanings, rate structure (standard is four), and retiree dental benefits.**

Custom programs from Companion Life ... it’s easy to create a unique plan with the Companion Life **Dental by Design** portfolio. Select the benefit design that works for you, then choose your option(s) on our convenient Request for Proposal (RFP) form.

Your group has selected the Dental Choice plan, but would prefer to have cleanings covered only once a year with coinsurance options of 80/80/50. Simply check the appropriate benefit options on your RFP form. Our Underwriting staff will provide a proposal for your custom-made Dental by Design plan.

EXAMPLE



INNOVATIVE DENTAL INSURANCE SOLUTIONS

Take a look at our plans! First select the standard benefit plan that best meets your needs. Dental Essentials, Dental Choice and Dental Select provide a choice of effective benefit solutions to fit any budget.

STANDARD BENEFIT DESIGNS

SERVICES	DENTAL ESSENTIALS	DENTAL CHOICE	DENTAL SELECT
Program Deductible			
Per Individual	\$100 Lifetime	\$100 Lifetime	\$100 Lifetime
Family Limit	No Limit	No Limit	No Limit
Waived for Type I Services?	No	No	No
Type I	100%	100%	100%
Preventive Services	oral exams, cleanings (two per 12 months), bitewing X-rays (one per 12 months)	oral exams, cleanings (two per 12 months), bitewing X-rays (one per 12 months), space maintainers, pain treatment, sealants	oral exams, cleanings (two per 12 months), bitewing, X-rays (one per 12 months), space maintainers, pain treatment, sealants, full mouth X-rays
Type II	80%	80%	80%
Basic Services	space maintainers, fillings, pain treatment, sealants, full mouth X-rays	full mouth X-rays, fillings, simple extractions, endodontics	fillings, anesthesia, endodontics, simple and surgical extractions, oral surgery, periodontics
Benefit Waiting Period	None	None	None
Type III	50%	50%	50%
Major Services	anesthesia, endodontics, simple and surgical extractions, oral surgery, periodontics, crowns, inlays onlays, dentures, bridges, implants	anesthesia, surgical extractions, oral surgery, periodontics, crowns, inlays onlays, dentures, bridges, implants	crowns, inlays, onlays, dentures, bridges, implants
Benefit Waiting Period	12 months	12 months	12 months
Contract Year Maximum	\$1,000	\$1,200	\$1,500
Type IV Orthodontia (Optional)	50%	50%	50%
Lifetime Maximum	\$1,000	\$1,000	\$1,000
Deductible	None	None	None
Benefit Waiting Period	12 months	12 months	12 months

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

Companion Life Insurance Company has specialized in group benefits for more than 30 years. We have earned A.M. Best's rating of A+ (Superior) due to our fiscal strength, investment practices and sound operational and management structure. At Companion Life we are committed to financial strength, effective corporate management and the highest level of service and responsiveness to our clients and sales associates.

COMPANION LIFE

**Here's what you need
for a Companion Life
Dental by Design proposal:**

Group Name
State and ZIP Code
Nature of Business or SIC Code
Proposed Effective Date
Current and Renewal Rates for
Inforce Dental Coverage (if any)
Selected Benefit Design
Dental Essentials,
Dental Choice or
Dental Select
Benefit Options Requested (if any)
for a Custom-Designed Plan
Premium and Claim Experience for
Employer Groups of 100 or More

Or, you can complete the convenient Companion Life Request for Proposal (RFP) form, which details the available options.

**Companion Life's Dental
Insurance Portfolio also includes:**

Dental "Cents" for groups
of 2-9 employees
Voluntary dental plans for groups
with as few as three employees

**For more information
or a proposal please contact:**

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

www.CompanionLife.com

Or call Group Marketing
at 800-753-0404
800-836-5433 (Fax)

FREEDOM OF CHOICE

What does freedom of choice mean to you? You can use your own dentist! There are no network restrictions of any kind with Companion Life Dental Insurance plans.

What are the advantages of having a dental program? An enhanced employee benefit program; Improved employee health and attendance; A boost in employee morale; A competitive edge when recruiting and retaining talented employees. Furthermore, the Surgeon General's 2002 report on *Our Health for America* notes that cost is the major impediment to obtaining adequate dental care. Fifty-six percent of employees without dental insurance rank it, after medical coverage, as the most-desired employee benefit.

What are the employer contribution and employee participation requirements? For employer contribution plans, a minimum of 25 percent employer contribution and 50 percent employee participation is required. There is no dependent participation requirement. For 100 percent employee paid plans, either 20 percent employee participation or three employees must participate, whichever is greater.

Can I use my own dentist? Yes! With *all* Companion Life dental plans you have freedom of choice to visit any dentist.

How can I, or my dentist, check my claim's status? Use our secure online tool, My Insurance CompanionSM! Go to www.CompanionLife.com and click on Members from the home page. Dentists can click on Providers. Check claim status, request an ID card, ask Customer Service, and more! Or, use our voice activated response system. These services are available seven days a week. Or, simply call 1-800-765-9603.

How are claims filed? Your dentist's office can file your claim for you. Companion Life will accept your dentist's claim form by mail or fax. Your dentist can file claims online at www.CompanionLife.com with My Insurance Companion.

TAKEOVER BENEFITS

Takeover means that we give employees credit for waiting periods they have accumulated for similar coverages under your current group dental plan.

Standard Takeover – An employee's waiting period will be reduced by the amount of time her or she was insured under your prior group dental plan. The prior dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan. All waiting periods will apply to future new employees.

Preferred Takeover – The waiting period(s) for existing employees including those who weren't on the prior plan will be waived. The prior dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan. All waiting periods will apply to future new employees.

Incentive Plan Takeover – If this group dental policy replaced the employer's prior group dental insurance policy that was in effect the day before this policy became effective and takeover benefits have been approved by Companion Life, all employees insured under the prior plan on the date the prior plan terminated are eligible for appropriate credit for time served under the prior dental policy.



Your *dental by design* Proposal

Thank you for reviewing this information about the *dental by design* portfolio from Companion Life. This program of employer-funded Dental plans offers real flexibility and great sales potential and we want to make sure that we clearly communicate how this unique portfolio works.

Every time you request a *dental by design* proposal, you will receive rates for the three Standard Benefit Designs — Dental Essentials, Dental Choice, and Dental Select — based on your prospect's demographics. Your Request For Proposal (RFP) form shows the numerous Design Options available for each of these standard plans. If you don't select any Design Options, your proposal will show rates and benefits for only the three standard plans. If you do select some of the Design Options available for one of the standard plans, your requested plan design will appear as the "Requested Design" on the proposal.

The proposal also includes complete information about our new Takeover Provisions and clear definitions for dental services and procedures.

We hope you'll agree that your *dental by design* portfolio is "tailor made" to meet your marketing needs. Please call for more information — or a proposal — today!

Group Marketing
(800) 753-0404
(800) 836-5433 (Fax)

dental by design

IMPORTANT INFORMATION

FREEDOM OF CHOICE

This Dental program from Companion Life provides total access to **any dentist**, giving your employee the freedom to choose a provider and needed services. Benefit payment allowances vary, depending on the area in which the services are rendered.

PLAN DESIGN

Dental by Design offers three basic benefit design platforms from which to choose. A wide range of program alternatives is available to build a benefit package to meet the individual needs of any employer group. Choose from a large selection of options for deductibles, waiting periods, benefit maximums, coinsurance, takeover benefits and much more.

TAKEOVER PROVISIONS FOR DENTAL BENEFITS

Standard Takeover – An employee's waiting period will be reduced by the amount of time they were insured under your prior group dental plan. The prior dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan. All waiting periods will apply to future new employees.

Preferred Takeover – The waiting period(s) for existing employees including those who weren't on the prior plan will be waived. The prior dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan. All waiting periods will apply to future new employees.

Incentive Plan Takeover – If this group dental policy replaced the employer's prior group dental insurance policy that was in effect the day before this Policy became effective and Takeover Benefits have been approved by Companion Life, all employees insured under the prior plan on the date the prior plan terminated are eligible for appropriate credit for time served under the prior dental policy.

DEFINITIONS

Endodontics – The treatment of pathological conditions within the pulp chamber of a tooth or involving the root of a tooth; includes root canal procedures.

Oral Surgery – Operative procedures performed in and about the oral cavity and jaws that are not performed in connection with periodontic and endodontic surgical procedures.

Periodontics – The treatment of diseases of the tissues surrounding and supporting the tooth. It includes the gingiva (gum tissue), cementum, alveolar (supporting) bone, root planing and periodontal cleaning.

Preventive Services – Oral examinations and cleanings are covered.

Simple Extraction – Uncomplicated removal of a tooth; not a cutting procedure.

Surgical Extraction – Removal of a tooth by means of surgical methods, usually involving the turning of a gingival flap or removal of bone.

X-rays – One full mouth or Panorex X-ray will be allowed in any 36-month period. One series of bitewing x-rays will be allowed in a twelve-month period under the standard plan designs.

Covered Implant Services – Available to adults and dependent children age 17 and older. Implant services include the accompanying crown and are incurred on final placement of the prosthetic.



Companion Life Insurance Company • P.O. Box 100102 • Columbia, South Carolina 29202-3102

1-800-753-0404

FAX (803)735-0736

REQUEST FOR PROPOSAL (RFP)

SHADED AREAS MUST BE COMPLETED

Date _____	Date Needed _____
------------	-------------------

Group Name _____

City _____ ST _____ Zip _____

Nature of Business or SIC Code _____
of Employees _____

Requested Effective Date: ____ / ____ / ____

Current Carrier(s) _____

Comments or Special Requests: _____

STANDARD % FLAT

STANDARD % FLAT

CLASS DESCRIPTION – employees in the classes below are to be quoted for the benefits listed at right.

Employer Contribution → _____ %
Current Rate → _____ Per \$1,000
Renewal Rate → _____ Per \$1,000

DENTAL

DENTAL "CENTS" (2 to 9)

Percent of Premium Paid By Employer:

- Single/Employee Only _____% (25% required)
- Family/Employee & Dependents _____%
- PLAN A** (100/80/50) \$1,000 Max., \$100 lifetime deductible
- PLAN B** (100/80/50) \$1,000 Max, \$25 and \$50 contract year deductibles
- PLAN C** (100) \$1,000, \$15 Copay Plan
- PLAN D** (100/80/50) \$1,000 Max, \$50 contract year deductible
- TAKEOVER – PRIOR PLAN**
- ORTHODONTIA (available for Plan A, Plan B and Plan D only)**
- ORTHODONTIA TAKEOVER** Yes No

DENTAL BY DESIGN (10 +)

(SEE REVERSE FOR PLAN DESIGN AVAILABILITY AND TO REQUEST A DENTAL PLAN.)

CURRENT RATES

RENEWAL RATES

Employee \$ _____	Employee \$ _____
E + Sp \$ _____	E + Sp \$ _____
E + Ch \$ _____	E + Ch \$ _____
Family \$ _____	Family \$ _____

Percent of Premium Paid By Employer:

- Single/Employee Only _____%
- Family/Employee & Dependents _____%

Is this Takeover Coverage? Yes No

If Yes, total years with Current Carrier _____

Claims Experience Attached (Required for Groups of 100+)

Please complete all sections applicable to the coverages for which you are requesting a proposal. Complete the other side, or attach census data to this RFP.

Producer's Name as to Appear on Proposal _____

Agency Name _____

Address _____

City _____ State _____ Zip _____

Phone Number: () _____

Fax Rates to: () _____ Attn: _____

E-mail Address: _____

LIFE AD&D

FLAT AMOUNT

\$ _____ on all Full-time Employees

MULTIPLE OF EARNINGS

_____ x Earnings on all Employees to max of \$ _____

CLASS PLAN

(List benefits below.)

LIFE REDUCTIONS

35% at 65, Terminate at 70 or Retirement (Groups of 2 to 9)

35% at 65, 50% at 70, 75% at 75. Terminate at Retirement (Groups of 10+)

Other _____

Extended Death Benefit (2-9 Employees)

Waiver of Premium (10+ Employees)

Dependent Life Amount Spouse \$ _____ Child(ren) \$ _____

Life Claims Experience Attached (Groups of 150 +)

VOLUNTARY?

- Yes
- No

STD

FLAT AMOUNT

\$ _____ / week on all Full-time Employees

PERCENT OF EARNINGS

_____ % of Earnings to a max benefit of \$ _____ / week

CLASS PLAN

(List benefits below.)

SHORT TERM DISABILITY

_____ day(s) accident

_____ days sickness

_____ weeks

VOLUNTARY?

- Yes
- No

LTD

PERCENT OF EARNINGS

_____ % of Earnings to \$ _____ max monthly benefit on all Full-time Employees (STANDARD)

CLASS PLAN

(List benefits below.)

ELIMINATION PERIOD

- 90 Days 180 Days
- 120 Days Other _____

BENEFIT INTEGRATION

- Primary and Family (Standard)
- Primary Only

BENEFIT DURATION

- To Age 65 RBD
- 5 Year 2 Year

OWN OCC DEFINITION

- 2 Yr. 3 Yr. 5 Yr.
- To 65

LTD Claims Experience Attached (Groups of 200+)

VOLUNTARY?

- Yes
- No



STANDARD BENEFIT DESIGNS

For Groups of 10 or More

Services	<input type="checkbox"/> Dental Essentials	<input type="checkbox"/> Dental Choice	<input type="checkbox"/> Dental Select
Program Deductible Per Individual Family Limit Waived for Type I Service?	\$100 Lifetime No Limit No	\$100 Lifetime No Limit No	\$100 Lifetime No Limit No
Type I – Preventive Services	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment sealants, full mouth X-rays
Type II – Basic Services (Waiting Period)	80% space maintainers, fillings, pain treatment, sealants, full mouth X-rays None	80% full mouth X-rays, fillings, simple extractions, endodontics None	80% fillings, anesthesia, simple & surgical extractions, endodontics, oral surgery, periodontics None
Type III – Major Services (Waiting Period)	50% anesthesia, endodontics, simple & surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants 12 months	50% anesthesia, surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants 12 months	50% crowns, inlays, onlays, dentures, bridges, implants 12 months
Contract Year Maximum	\$1,000	\$1,200	\$1,500
Type IV – Orthodontia \$1,000 Lifetime Maximum Deductible (Waiting Period)	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months
Takeover Benefit	Preferred	Preferred	Preferred
<input type="checkbox"/> NO DESIGN OPTIONS – Issue Standard Benefit Design (above)			

– OR –

Choose Design Options (if any) (below)	Dental Essentials	Dental Choice	Dental Select
Incentive Plan - Percentage Increases in 2 nd and 3 rd years; No Waiting Periods Apply; Incentive Plan Takeover Only; If Selected, Child Orthodontia Max is \$375 annually and \$1,000 Lifetime.	<input type="checkbox"/> Yes <input type="checkbox"/> No 1 st yr./2 nd yr./3 rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%	<input type="checkbox"/> Yes <input type="checkbox"/> No 1 st yr./2 nd yr./3 rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%	<input type="checkbox"/> Yes <input type="checkbox"/> No 1 st yr./2 nd yr./3 rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%
Contract Year Deductible per Individual Limit Per Family Waive Deductible for Type I Services? (N/A for Lifetime Deductible)	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequency of Cleanings / Exams	<input type="checkbox"/> 1 per 12 months	<input type="checkbox"/> 1 per 12 months	<input type="checkbox"/> 1 per 12 months
Frequency of Bitewing X-Rays	<input type="checkbox"/> 2 per 12 months	<input type="checkbox"/> 2 per 12 months	<input type="checkbox"/> 2 per 12 months
Change the Contract Year Maximum	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$2,000
Add Retiree Dental Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change the Premium Rate Structure (Standard is Four Tiers)	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Three Tiers	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Three Tiers	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Three Tiers

THE FOLLOWING DESIGN OPTIONS ARE NOT AVAILABLE WITH THE INCENTIVE PLAN

Change Coinsurance	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50
Add a Type II Waiting Period Six Month Wait for Fillings Only	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes
Change the Type III Waiting Period	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months
Increase the Contract Maximum by \$250 per Year Maximum Cap after Increases \$2,500/yr.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases
Change the Orthodontia Option Orthodontia Lifetime Maximum Orthodontia Waiting Period Adult Orthodontia	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No
Takeover Option	<input type="checkbox"/> Standard Takeover	<input type="checkbox"/> Standard Takeover	<input type="checkbox"/> Standard Takeover

Your proposal will always include rates for the three Standard Benefit Designs. If no options are requested, please check the box "Propose Standard Benefit Designs – No Options." To request a Custom Benefit Plan, select one of the three Standard plans and select any changes to the Standard Benefit Design from the "Available Design Options" for that Plan.



LIMITATIONS:

I. COVERED EXPENSES WILL NOT INCLUDE, AND NO BENEFITS WILL BE PAYABLE:

1. For Class III and Class IV Procedures in the first 12 months that a person is insured, except as may be provided in the Takeover Benefits provision. This exclusion does not apply to Incentive Plans.
2. For any treatment which is for cosmetic purposes, or to correct congenital malformations other than medically necessary treatment of congenital cleft in the lip or palate, or both.
3. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items. Replacement of an existing implant supported prosthetic device is covered only once every ten (10) years from the placement date of such device and only then if it is unserviceable and cannot be made serviceable. However, if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under this policy it will be a covered expense.
4. For initial placement of any prosthetic appliance, implant or fixed bridge unless such placement is needed because of the extraction of one or more natural teeth while the Insured is covered under this policy. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.
5. For any procedure begun before coverage begins or after the Insured's coverage terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's coverage terminates.
6. To replace lost or stolen appliances.
7. For 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 abrasion or attrition
 - d. treat disturbances of the temporomandibular joint
8. Charges for a missed appointment, consultations or for completion of claim forms.
9. If applicable, orthodontia covered charges will not include charges for services:
 - a. payable under any other provisions or policy
 - b. rendered in the first 12 months the insured person is covered under the policy
 - c. incurred by employee or spouse, or incurred by dependent children after reaching the age of 19 (unless adult and child(ren) orthodontia option is selected)
10. For sealants which are:
 - a. not applied to a permanent molar
 - b. applied after attaining age 16
 - c. reapplied to a molar within three years from the date of a previous sealant application
11. For application of fluoride after attaining age 19.
12. Because of an injury arising out of, or in the course of, work for wage or profit or eligible for benefits under Worker's Compensation.
13. For services which are not recommended by a dentist or which are not required for necessary care and treatment.
14. For services related to equilibration, bite registration or bite analysis.
15. Crowns for the purpose of periodontal splinting.
16. Charges for any precision or semi-precision attachments, and any endodontic treatment associated with it, or other customized attachments.
17. For procedures not identified on the List of Dental Procedures in the Master Policy.
18. No benefit will be provided for implants or implant services where loss of the tooth was prior to the Insured's effective date of coverage under this dental plan.

II. PAYMENT FOR SERVICES SHALL BE LIMITED AS FOLLOWS:

If this plan replaces another plan of similar benefits and as a result offers takeover benefits, we limit what we pay to the lesser of: (a) what the prior plan would have paid, or (b) what this plan would usually pay. We will deduct any benefits actually paid by the prior plan under any extension provision.

EMPLOYER APPLICATION FOR GROUP DENTAL INSURANCE

dental by design
A COMPLETE DENTAL INSURANCE PORTFOLIO FROM COMPANION LIFE.



Companion Life Insurance Company • PO Box 100102 • Columbia, South Carolina 29202-3102
1-800-753-0404 • FAX (803) 735-0736

Please Print or Type

EMPLOYER INFORMATION

1. Full legal name of applicant (As it should appear in policy)		Telephone Number ()	
2. Applicant's Federal Tax ID Number			
3. Address	Street	Post Office Box	ZIP
City		County	State
4. Administrative Correspondence with the Applicant should be addressed to: Name _____ Title _____			
5. Nature of Business		6. Requested Effective Date:	
7. Are there subsidiary businesses covered under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please state name and nature of each subsidiary or affiliate.	
Are separate billings required? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please provide billing instructions.	
8. Type of Administration:		<input type="checkbox"/> Home Office Administered	<input type="checkbox"/> Self Administered

EMPLOYEE ELIGIBILITY

9. The normal work week for full-time employees must be at least 30 hours unless otherwise approved by Companion Life.	
10. Current eligible employees are to be covered: <input type="checkbox"/> Immediately on the requested effective date. <input type="checkbox"/> After _____ days of continuous employment. <input type="checkbox"/> First of the month following _____ days of continuous employment.	11. Employees hired after the plan effective dates are to be covered: <input type="checkbox"/> Immediately. <input type="checkbox"/> After _____ days of continuous employment. <input type="checkbox"/> First of the month following _____ days of continuous employment.
12. Coverage following completion of the waiting period selected will be effective the first of the month following completion of the waiting period or the next billing date.	
13. Number of Eligible Employees: _____	14. Number of Enrolled Employees: _____

SPECIFICATIONS FOR INSURANCE

15. Percent of Premium Paid by Employer: <input type="checkbox"/> Single/Employee Only <input type="checkbox"/> Family/Employee & Dependents _____%		
16. Will this coverage replace any existing dental insurance plan? If YES, name present insurance carrier: <input type="checkbox"/> Yes <input type="checkbox"/> No		
17. Existing Plan Effective Date:	18. Termination Date of Existing Plan	19. Check coverages being replaced: <input type="checkbox"/> Preventive <input type="checkbox"/> Basic <input type="checkbox"/> Major <input type="checkbox"/> Orthodontia
20. Is prior insurance credit (takeover benefits) requested? <input type="checkbox"/> Yes <input type="checkbox"/> No		
21. The following documentation is required when prior insurance credit is requested. Your current dental plan must have been in effect continuously for at least 12 months prior to effective date. <ul style="list-style-type: none">• Evidence that the prior carrier's coverage has been in force for at least 12 months.• A copy of the most recent bill which includes a listing of all covered employees.• A list of the covered employees with the prior carrier which includes the employee's effective dates of coverage.• A copy of the inforce dental plan which may be a contract, certificate, or booklet.		

22. Select Standard Benefit Design (REQUIRED)	<input type="checkbox"/> Dental Essentials	<input type="checkbox"/> Dental Choice	<input type="checkbox"/> Dental Select
Program Deductible (all services)	\$100 Lifetime	\$100 Lifetime	\$100 Lifetime
Type I – Preventive Services	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants, full mouth X-rays
Type II – Basic Services (Waiting Period)	80% space maintainers, fillings, treatment, sealants, full mouth X-rays None	80% full mouth X-rays, fillings, simple extractions, endodontics None	80% fillings, anesthesia, simple & surgical extractions, endodontics, oral surgery, periodontics None
Type III – Major Services (Waiting Period)	50% anesthesia, endodontics, simple & surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants 12 months	50% anesthesia, surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants 12 months	50% crowns, inlays, onlays, dentures, bridges, implants 12 months
Contract Year Maximum	\$1,000	\$1,200	\$1,500
Type IV – Orthodontia \$1,000 Lifetime Orthodontal Maximum Deductible (Waiting Period)	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months	50% <input type="checkbox"/> Yes <input type="checkbox"/> No None 12 months
Takeover Benefit	Preferred	Preferred	Preferred

23. **NO DESIGN OPTIONS – Issue Standard Benefit Design (above)**

– OR –

24. Choose Design Options (if any) (below)	Dental Essentials	Dental Choice	Dental Select
Incentive Plan – Percentage Increases in 2 nd and 3 rd years; No Waiting Periods Apply; Incentive Plan Takeover Only; If Selected, Child Orthodontia Max is \$375 annually and \$1,000 Lifetime	<input type="checkbox"/> Yes <input type="checkbox"/> No 1 st yr./2 nd yr./3 rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%	<input type="checkbox"/> Yes <input type="checkbox"/> No 1 st yr./2 nd yr./3 rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%	<input type="checkbox"/> Yes <input type="checkbox"/> No 1 st yr./2 nd yr./3 rd yr. Type I-80%/100%/100% Type II-50%/65%/80% Type III-25%/35%/50% Type IV-25%/35%/50%
Contract Year Deductible Amount per Individual Limit Per Family Waive Deductible for Type I Services? (N/A for Lifetime Deductible)	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> No Limit <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequency of Cleanings / Exams	<input type="checkbox"/> 1 per 12 months	<input type="checkbox"/> 1 per 12 months	<input type="checkbox"/> 1 per 12 months
Frequency of Bitewing X-Rays	<input type="checkbox"/> 2 per 12 months	<input type="checkbox"/> 2 per 12 months	<input type="checkbox"/> 2 per 12 months
Change the Contract Year Maximum	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$2,000
Add Retiree Dental Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change the Premium Rate Structure (Standard is Four Tiers)	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Three Tiers	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Three Tiers	<input type="checkbox"/> Two Tiers <input type="checkbox"/> Three Tiers

THE FOLLOWING DESIGN OPTIONS ARE NOT AVAILABLE WITH THE INCENTIVE PLAN:

Change Coinsurance	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> 100/50/50 <input type="checkbox"/> 80/80/50
Add a Type II Waiting Period Six Month Wait for Fillings Only	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Yes
Change the Type III Waiting Period	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months	<input type="checkbox"/> No Waiting Period <input type="checkbox"/> 6 months <input type="checkbox"/> 24 months
Increase the Contract Maximum by \$250 per Year Maximum Cap after Increases \$2,500/yr.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 2 Increases <input type="checkbox"/> 3 Increases
Change the Orthodontia Option Orthodontia Lifetime Max Orthodontia Waiting Period Adult Orthodontia	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> 24 months <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No
Takeover Option	<input type="checkbox"/> Standard Takeover	<input type="checkbox"/> Standard Takeover	<input type="checkbox"/> Standard Takeover

EMPLOYER'S SIGNATURE

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.

Quotations were based on the proposal data submitted to Companion Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

Dated at _____ this _____ day of _____, 20 _____
City/State

Signature of Employer Title Witness

AGENT'S REPORT

25. Initial Deposit (Minimum first month's premium is required.) 26. Agent/Broker Name (Please Print) Telephone Number
\$ ()

27. Address Post Office Box

City County State ZIP

28. Are there other group insurance plans which duplicate any of the benefits applied for with this application that will remain in force or be placed concurrently with this plan(s)?
 Yes No If YES, please describe the benefit amounts and purposes of these plans:

29. Is Agent or Broker licensed and appointed by Companion for the types of insurance solicited where this group is located?
 Yes No Agent Code Number _____ State License _____

30. Signature of Agent/Broker _____ Date _____



www.CompanionLife.com



RETIREE DENTAL/VISION ELECTION FORM

P.O. Box 100102 • Columbia, SC 29202-3102
1-800-753-0404 • Fax (803) 735-0736

First Name

Middle Initial

Last Name

I am age 55 or older, I am retiring and I am currently enrolled in Companion Life's dental plan through my employer. I wish to continue my Companion Life:

- Dental Benefits
- Dental and Vision Benefits

For:

- myself only
- myself and my currently covered dependent(s).

I understand that I will be billed at home and that an extra \$5.00 monthly administrative fee will be added to my premium.

Signed: _____ Date: _____

Required to be Completed by Employer:

As the group administrator for (group name) _____
(group number) _____, I certify that the above employee has
voluntarily terminated his/her employment with our company on (retirement date) _____
and is eligible to continue dental/vision benefits as a retiree for as long as our policy is in effect with
Companion Life.