DENTAL APPLICATION

Small Business Advantage® powered by ALLIED NATIONAL

Fidelity Security Life Insurance Company
Kansas City, Missouri 64111

Allied National
P.O. Box 29187
Shawnee Mission, KS 66201-9189

GROUP INFORMATION

Legal name of Employer Applicant (Policyholder):			**Administration Only** Allied Case #
Applicant's Phone Number: ( )	Federal Tax ID No.:		
Nature of Business:	SIC Code:	Email Address:	
Mailing Address:	City:	State:	Zip Code:
Street Address (if different from above):	City:	State:	Zip Code:
Name of Subsidiaries, Divisions 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 $_____ (first month's premium) is submitted herewith to be applied by the Company to premiums for insurance when and if issued.

ELIGIBILITY

Eligible Employees:
30 Minimum Hours per Week _____ Number Eligible

❑ All Full Time Employees ❑ Other

Employee Benefit Waiting Period: 0 / 30 / 60
Current Employees: _____ Day Waiting Period
New Employees: _____ Day Waiting Period

Any excluded classes of employees ❑ Yes ❑ No If yes, give details below:

Effective Date of Coverage / Termination Date of Coverage
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

Late Enrollee restrictions apply: ✓ Yes

Will this plan be part of a Sec. 125 Salary Reduction Plan ❑ Yes ❑ No,
If yes, attach a copy of the Sec. 125 document page

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	Type of Coverage	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).

– SEE OTHER SIDE –

PREMIUM / MONTHLY COST

Premium Information: ❑ 100% Employer Paid OR

Employer % of Employee Premium (minimum 25%): _____%
Employer % of Dependent Premium:_____ %

SCHEDULE OF BENEFITS

Attach Proposal - As shown on the attached proposal as signed by the employer.

AGREEMENT AND SIGNATURES

It is understood and agreed as follows:

1. No coverage is effective until approved by Fidelity Security Life Insurance Company at its home office in Kansas City, Missouri.
2. Insurance will be effective with regard to those individuals listed in the Eligibility Section on the later of the following dates: (a) the effective date approved by the Company; (b) the date this 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 rights or requirements, or to make or alter any contract or policy.
4. The employer applicant agrees to make the appropriate premium deductions from each insured 's payroll check, if applicable, and remit to Fidelity Security Life Insurance Company or its Administrator within 30 days of the deduction.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Dated at: _____ this _____ day of _____, _____.

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 Code

SPECIAL REQUEST

Send Administration Kit, Certificates, and ID Cards to Broker