



Fidelity Security Life Insurance Company
 Kansas City, Missouri 64111

DENTAL APPLICATION

Matrix

PPO Option

Flexident – Plan Name: _____

GROUP INFORMATION

| | | | |
|--|-------|----------------------|--------------------|
| Legal name of Employer Applicant (Policyholder): | | | |
| Applicant's Phone Number: () | | Federal Tax ID No.: | |
| Nature of Business: | | SIC Code: | |
| 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 \$ _____ is submitted herewith to be applied by the Company to premiums for insurance when and if issued. | | | |

ELIGIBILITY

| | |
|---|--|
| Eligible Classes: _____ Minimum Hours per Week _____ Weeks per Year <input type="checkbox"/> All Full Time Employees _____ Number Eligible <input type="checkbox"/> Other | Employee Benefit Waiting Period: <input type="checkbox"/> 0 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 days <input type="checkbox"/> _____ Current Employees: _____ Day Waiting Period New Employees: _____ Day Waiting Period |
| Any excluded classes of employees <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details on reverse side | |
| Effective Date of Coverage / Termination Date of Coverage Option 1 <input type="checkbox"/> Effective Immediately/Terminated on the last day for which premium has been paid Option 2 <input type="checkbox"/> 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 | |
| Note: Option 2 always applies to voluntary coverage | |
| Late Enrollee restrictions apply: <input type="checkbox"/> Yes <input type="checkbox"/> No (Note: Late Enrollee restrictions do not apply to voluntary coverage) | |
| Will this plan be part of a Sec. 125 Salary Reduction Plan <input type="checkbox"/> Yes <input type="checkbox"/> No, If yes, attached 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

| Billing Class | # Covered | Cost | Total |
|---------------|-----------|----------------------|----------|
| _____ | x | \$ _____ | \$ _____ |
| _____ | x | \$ _____ | \$ _____ |
| _____ | x | \$ _____ | \$ _____ |
| _____ | x | \$ _____ | \$ _____ |
| _____ | x | \$ _____ | \$ _____ |
| | | Monthly Billing Fee: | \$ _____ |
| | | Total Monthly Cost: | \$ _____ |

Premium Information: 100% Employer Paid OR
 Employee Coverage: _____ Employer Coverage: _____ Employee Contribution: _____ Area Factor Quoted: _____
 Dependent Coverage: _____ Employer Contribution: _____ Employee Contribution: _____ Zip Code Quoted: _____

SCHEDULE OF BENEFITS

| | Benefit Waiting Period | Deductible Amount per Person | Coinsurance Percentage |
|-----------------|--|--|------------------------|
| Preventive Care | _____ | _____ | _____ |
| Diagnostic Care | _____ | _____ | _____ |
| Basic Care | _____ | _____ | _____ |
| Major Care | _____ | _____ | _____ |
| Prosthodontics | _____ | _____ | _____ |
| Orthodontics | _____ | _____ | _____ |
| Prosthodontics | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, Calendar Year Limit \$ _____ Lifetime Maximum \$ _____ | |
| Orthodontics | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, Calendar Year Limit \$ _____ Lifetime Maximum \$ _____ | |

NOTE: If the PPO Option is checked, benefits payable under the Policy will decrease each time an Insured uses a Non-Preferred Provider. Please refer to the Policy for more information.

AGREEMENT AND SIGNATURES

It is understood and agreed as follows:

- No coverage is effective until approved by Fidelity Security Life Insurance Company at its home office in Kansas City, Missouri.
- 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.
- No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
- 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.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company or Administrator by mail, email, or telephone.

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 REQUESTS

Send Administration Kit, Certificates, and ID Cards to: Broker Policyholder

FRAUD WARNING NOTICE

| | |
|---|--|
| For residents of all states (except the following:) | 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. |
| Alabama | Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof. |
| Arkansas West Virginia | Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| Georgia Oregon Texas | 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 may be guilty of insurance fraud. |
| Kansas | 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 may be guilty of insurance fraud as determined by a court of law. |
| Maryland | Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| Nebraska | 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 false, incomplete or misleading information is guilty of insurance fraud. |
| New Jersey | Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. |
| North Carolina | Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties. |
| Oklahoma | WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. |
| Tennessee | It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. |
| Virginia | Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law. |