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
❑ All Full Time Employees _____ Number Eligible
❑ Other

Employee Benefit Waiting Period:
❑ 0 ❑ 30 ❑ 60 ❑ 90 days ❑ _____
Current Employees: _____ Day Waiting Period
New Employees: _____ Day Waiting Period

Any excluded classes of employees ❑ Yes ❑ No If yes, give details on reverse side

Effective Date of Coverage / Termination Date of Coverage

Option 1 ❑ Effective Immediately/Terminated on the last day for which premium has been paid

Option 2 ❑ 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: ❑ Yes ❑ No (Note: Late Enrollee restrictions do not apply to voluntary coverage)

Will this plan be part of a Sec. 125 Salary Reduction Plan ❑ Yes ❑ 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 ❑ Yes ❑ No If yes, Calendar Year Limit $ _____ Lifetime Maximum $ _____

Orthodontics ❑ Yes ❑ 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:

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.

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.

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.

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