# First Continental Life & Accident Insurance Company

## Application for Group Dental Service

Please complete this form by printing in ink or typing

Application is hereby made to First Continental Life & Accident Insurance Company (FCL), by the Applicant named below (Organization), for the purpose of making available certain dental services and benefits to all eligible individuals represented by Organization. The arrangement for such services and benefits shall be subject to the Group Dental Service Agreement, Certificate of Coverage and Schedule of Benefits attached hereto, and together these documents shall constitute the "Agreement".

Group Name _____ Proposed Effective Date _____

Address _____ City:_____ State: _____ ZIP:_____

Contact _____ Phone: _____ Fax _____

Tax ID # _____ Email Address _____ Tier Structure _____

SIC Code and Nature of Business _____ Total Eligible Employees _____

The monthly prepayment fee (as shown below) for each covered employee is due and payable from the Organization to FCL beginning on the date specified above as the effective date, and on the first day of each month this contract remains in force. The monthly rates shown below are guaranteed for one year.

**(Passive)** **Ortho Max:** _____

Plan Design: __ _____/_____/_____ Annual Max: _____

| Number of Employees to be Covered | | Monthly Rates |
|---|---|---|
| _____ | Employee Only (EE) | $ |
| _____ | Employee & Spouse (ES) | $ |
| _____ | Employee & Child(ren) (EC) | $ |
| _____ | Employee & Family (EF) | $ |
| _____ | Total Covered Employees | |

**Initial Premium Calculation**

# of EE employees
times monthly rate = $ _____

# of ES employees
times monthly rate = $ _____

# of EC employees
times monthly rate = $ _____

# of EF employees
times monthly rate = $ _____

**Total Initial Premium $** _____

In order for First Continental Life to determine whether or not Takeover Benefits are to be included, the following must be provided:
Name Of Prior Carrier:_____ Effective Date of Prior Plan:_____ Termination Date of Prior Plan: _____

**The employer must also submit a copy of (1) the prior carrier's most recent billing statement (2) a certificate or letter of acceptance that shows the effective date of the prior plan; and (3) the prior carriers' certificate, booklet or schedule of benefits.**

Coverage is for: Employees Only _____ Employees and Dependents _____
Employment Waiting Period: 1 Month _____ Other _____

(No elimination period applies to those employees on the effective date)
(Coverage following completion of the waiting period will be effective on the first day of a calendar month only)

The employer agrees to contribute the following percentages or monthly dollar amounts toward the overall cost of dental insurance:

| | | | |
|---|---|---|---|
| Employees: | None: _____ | %age of single-employee cost: _____ | $ amount: _____ |
| Dependents: | None: _____ | %age of single-employee cost: _____ | $ amount: _____ |

It is understood and agreed as follows: 1) No coverage is effective until approved by First Continental Life & Accident Insurance Company (FCL) at its Home Office in Sugar Land, Texas; and 2) No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.

_____ _____
Signature of Applicant Date Signature of Agent Date

_____ _____
Print Name & Title Agent's Name / License Number



Deliver Membership Information to: O Agent O Benefits Manager