

Group Insurance Enrollment Card

- Check one – Employer Use**
- Initial Employee:**
 - Transfer from Prior Dental
 - Non-Transfer
 - New Employee**
Date of Hire _____
 - Change**
 - Open Enrollment**

(Please print clearly.)

Employer Contractors Management Services LLC		Effective Date 05/01/2007	Location/Division	
Employee first name		MI	Last Name	
Address		City	State	Zip
Social Security No.	Birthdate	Phone		Sex <input type="checkbox"/> M <input type="checkbox"/> F

DENTAL COVERAGE

I APPLY FOR:

- Employee only
- Employee and eligible dependents

I DECLINE COVERAGE FOR:

- Employee
- Spouse
- Child(ren)

Do you have eligible dependents? Yes No
If "Yes," complete below to enroll them.

	Relation	Sex	Birthdate			For children age 19 or older, indicate if a full-time student.	
			Mo	Day	Year	Yes	No
Spouse							
Child(ren)							

List additional Children on reverse side and check box.

- If the address of any child is different than the employee's address, please show that **child's name and address** below.

- Name of the custodial parent or organization requesting coverage for such dependent child

- Name of the custodial parent or organization responsible for payment of premium for such dependent child

- If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.

I hereby apply as indicated herein for the insurance for which I am not now insured and for which I am or may become eligible under the terms of Fortis Benefits Insurance Company's group policy or policies (including any future amendments) applying to, or requested to apply to, the employer named above. If such insurance becomes effective, I authorize deductions from my earnings of my contributions required from time to time toward the cost of such insurance. I represent that I am an active full-time employee of that employer. When necessary, I may be asked to execute a HIPAA authorization form, allowing Fortis Benefits Insurance Company to use and disclose protected health information.

Date _____ Signature _____

Savings You Can See

Monthly Payroll Deduction

Employee	\$21.98
Employee + Spouse	\$43.41
Employee + Child(ren)	\$50.19
Employee + Family	\$71.62

Freedom Advance

Benefit Maximum:

Per Person, Per Policy Year \$1,000

Coinsurance Percentage Per Person:

	Type I	Type II	Type III
During the 1 st Year	100%	80%	25%
During the 2 nd Year	100%	80%	50%
During the 3 rd Year and thereafter		100%	80%

Deductible:

Per Person, Per Policy Year \$50
 Waived for Type I Services Yes

If you are covered under the current dental program on the day it terminates, your benefits will begin at the 2nd policy year level with Type I 100%, Type II 80%, and Type III 50%.

Type I Preventive Dental Services, Including:

- ◆ Oral Evaluations - once in any 6-month period
- ◆ Routine Dental Cleanings - once in any 6-month period
(Frequencies combined with Periodontal Maintenance)
- ◆ Fluoride Treatment - once in any 12-month period
Only for children under age 14
- ◆ Sealants - No more than once per tooth per person, only for permanent molar teeth
Only for children under age 16
- ◆ Space Maintainer
Only for children under age 16
(Includes adjustments within 6 months of installation)
- ◆ Harmful Habit Appliance - once per person
Only for children under age 16
(Not covered if Orthodontic related)
- ◆ Bitewing X-Rays - once in any 12-month period

Type II Basic Dental Services, Including:

- ◆ X-Rays:
 - ◆ Complete series - once in any 60-month period
 - ◆ Panoramic - once in any 60-month period (may also be payable in connection with the removal of impacted teeth)
 - ◆ Other X-Rays (See Certificate of Insurance)
- ◆ New Fillings

- ◆ Replacement Fillings - once in any 24-month period per Filling
- ◆ Simple Extractions, Removal of Exposed Roots, Incision and Drainage
- ◆ Certain Lab Tests, Pain Treatment, Therapeutic Drug Injections
- ◆ Endodontics (includes root canal therapy)
- ◆ Endodontic retreatment (covered after 24 months have passed from initial treatment)
- ◆ Minor Gum Disease Treatment: (Minor Periodontics)
 - ◆ Provisional Splinting, Occlusal Adjustments - once in any 12-month period
 - ◆ Scaling and Root Planing - once in any 24-month period per area
 - ◆ Periodontal Maintenance - once in any 6-month period
(Frequencies combined with Routine Dental Cleanings)
- ◆ Major Gum Disease Treatment: (Major Periodontics)
 - ◆ Gingivectomy, Osseous Surgery, other major periodontic procedures - once in any 36-month period per area

Type III Major Dental Services, Including:

- ◆ Complex Oral Surgery; General Anesthesia and IV Sedation when medically required for such Surgery
- ◆ Initial Placement, Replacement and Maintenance of ~~50%~~ Onlays, Crowns, Fixed Partial Dentures (Bridges), and Partial and Complete Dentures

Other Policy Provisions

Benefit Adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care. If the cost of a proposed Dental Treatment Plan exceeds \$300, it should be submitted for an estimate of benefits payable.

Eligibility

Full-time employee, spouse and unmarried dependent children less than age 19 or 25 if a full-time student.

Late Entrants

If you elect coverage more than 31 days after your Eligibility Date, your Effective Date will be delayed to the next plan Anniversary Date.

This is a brief description only. It is not a Certificate of Coverage. Please see the Group Policy, which alone determines all rights, benefits, and applicable Limitations and Exclusions. Fortis Benefits and the policyholder have the option to cancel the group policy.