Preferred Insurance Services, Inc. Dental Plan

POLICYHOLDER APPLICATION

ENROLLEE INFORMATION		
NAME (Last, First, MI):	GENDER: Male Female	
ADDRESS:	DATE OF BIRTH: ___/___/___	
CITY:	STATE:	ZIP:

DEPENDENT INFORMATION			
Last, First, MI	Relationship to Enrollee	Date of Birth	Electing Dental Coverage
		___/___/___	Yes No
		___/___/___	Yes No
		___/___/___	Yes No
		___/___/___	Yes No
		___/___/___	Yes No

CURRENT DENTAL COVERAGE:

Check one of the choices below to indicate if the dental coverage will replace an existing dental plan.

☐ One of the applicants currently has dental coverage. This policy will replace a current policy.

☐ This policy will not replace any existing dental insurance coverage.

PREMIUM:

- This policy is subject to an Annual Maximum Benefit of: ____ [$750,$1500,$2500] per person.
- The premium is: _____ [$_____] per month (_____ [$_____] per year) payable on the first day of the Benefit Year and on the first day of each following month.

The premium may change at the beginning of a Benefit Year. The Plan will provide notice of any change in premium not less than 30 days prior to the first day of the Benefit Year for which such change is effective. If any change in premium is greater than 25%, the Plan will provide notice not less than 60 days prior to the first day of the Benefit Year for which such change is effective.

PLEASE CHECK ONLY ONE OF THE CHOICES BELOW:

____Yes, I elect coverage under the Preferred Insurance Services, Inc. Dental Plan program as indicated above. I understand that if I select a Participating Dentist, I will not incur any out-of-pocket cost for services in the Preferred Insurance Services, Inc. Dental Plan Schedule of Benefits **subject to the annual maximum in Section 9, limitations in Section 10 and exclusions in Section 11**.

___ NO, I do not want coverage under the Preferred Insurance Services, Inc. Dental Plan Program.

TO BE COMPLETED BY AGENT
Agent Signature:
Agent License #:
Date:

RENEWABILITY, CANCELLATION AND TERMINATION OF POLICY

Coverage under the Preferred Insurance Services, Inc. Dental Plan will be for a 12-month Benefit Year and will be effective (the "Coverage Effective Date") on the first day of a calendar month, as follows.

Upon receipt of paid premium, the Coverage Effective Date and the start of the Benefit Year for coverage will begin on the 1st day of the next month.

Premiums are payable in monthly installments beginning on the first day of a Benefit Year. Coverage will renew automatically on an annual basis, subject to termination or disenrollment as follows:

(a) You or the Preferred Insurance Services, Inc. Dental Plan may terminate coverage as of the last day of a Benefit Year upon not less than 60 days prior written notice of termination to the other;

(b) There is a 30-day grace period for premium payments. You must pay your premium before the end of the grace period. At that point, PI will terminate your coverage if premium is still unpaid. If non-payment of premium terminates your coverage, a subsequent acceptance of premium by PI or by any agent duly authorized by the insurer to accept such premium will reinstate coverage. Coverage becomes effective again as of the date of payment acceptance.

(c) You or Preferred Insurance Services, Inc. may terminate coverage at any time upon not less than 60 days prior notice to the other party. No refund of premium will occur if termination of coverage pursuant to this Section 3(c) occurs prior to the last day of the sixth month of the first Benefit Year. If termination of coverage pursuant to this Section 3(c) occurs after the last day of the sixth month of the first Benefit Year, Preferred Insurance Services, Inc. will refund you the unearned pro-rated premium based upon the "Premium Refund Table" filed with the Department of Insurance, less a 10% short rate penalty.

Preferred Insurance Services, Inc. advised me in good faith that this policy is suitable for my situation and me.

The Dental Plan provides coverage for services ONLY from Participating Dentists and only for the dental services listed in the policy Schedule of Benefits.

Preferred Insurance Services, Inc. will issue me a copy of the Policy and the included Dental Plan Schedule of Benefits within 30 days after receipt of my paid premium.

I hereby declare that the statements and answers provided on this Policyholder Application are true, accurate and complete on the date hereof.

Enrollee signature: _____ Date _____

RELEASE OF MEDICAL AND DENTAL RECORDS

I agree to the release of all my medical and dental records to Preferred Insurance Services, Inc. and/or its contracted dental provider.

These records will include treatment histories, diagnoses and any chronic health conditions, surgeries and prescription medications taken.

Preferred Insurance Services, Inc. will use this information solely to aid in understanding my health history as it pertains to future dental care.

Enrollee signature: _____ Date _____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

On page one of your application, you may have indicated you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by Preferred Insurance Services, Inc. Your new policy provides 10 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1) Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy insofar as excepted benefit policies and grandfathered health plans are concerned. Generally, excepted benefits involve coverage only for accident or disability income insurance, or coverage issued as a supplement to liability insurance, or other separately offered coverage such as dental or vision benefits. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny future claims and refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Enrollee signature: _____ Date _____

AUTO PAY FROM CHECKING OR SAVINGS ACCOUNT

If you wish to have the monthly premium automatically deducted from your Checking or Savings Account, complete the following authorization and sign and date below.

If you do not wish to set up the automatic premium deduction option, you do not need to complete this form.

I hereby authorize Preferred Insurance Services, Inc. or its authorized administrator and the bank named below, to initiate monthly debit entries for my dental premium:

Name of Account Holder:_____

Account Type: ☐ Checking ☐ Savings

Bank Name:_____

City:_____ State:_____ Zip:_____

Transit/ABA No:_____ Account No:_____

Attach a Voided Check for Checking/Savings Account Auto-Payment

By signing, I authorize the debiting of my checking or savings account for my dental premium. This includes any premium increases or reinstatement fees provided in the policy.

This authorization is to remain in full force and effect until I provide written notification to terminate the authorization and that notification has been received in such time and manner as to afford Preferred Insurance Services, Inc. or its authorized administrator a reasonable opportunity to act on it.

I understand that Preferred Insurance Services, Inc. or its authorized administrator may elect to terminate this payment convenience option at any time.

_____ _____

Signature of Account Holder Date