



EMPLOYER APPLICATION and REQUEST FOR PARTICIPATION

Name of Employer _____ Tel _____ Fax _____

Street Address _____ City _____ State _____ ZIP _____

Mailing Address _____ City _____ State _____ ZIP _____

Name of Correspondent: _____ Email _____

Affiliates or Subsidiaries to be covered: _____ Federal Tax ID # _____

1. Type of Business: Corporation Partnership Sole Proprietorship LLC Other _____

Nature of Business _____ SIC Code: _____

2. Are 50% or more of employees related: Yes (see Sales Guide, Note: Husband and wife two person groups are ineligible) No

3. Eligibility:

Employees employed on or prior to the Effective Date: Waiting Period applies: Yes No

Employees employed after the Effective Date will become eligible on the 1st day of the month corresponding with or next following (check one):

One Month's Service Two Month's Service Three Month's Service Date of full-time hire Other _____

Eligible employees who are disabled on the date their insurance would otherwise become effective shall become insured on the date they return to active work.

4. Employee/COBRA Eligibility: Do you employ 20 or more employees? (Include part-time, union, etc.) Yes No

Eligible employees are: full-time employees who devote a minimum of 30 hours per week to the service of the employer and who have met the waiting period.

Total number of full-time employees _____
(include employees not to be covered)

Total number of full-time employees _____
refusing coverage

Total number of COBRA eligible participants _____

Total number of full-time employees _____
eligible for coverage on the eff. date

5. Employer Contributions: (Employer must contribute at least 25% of the total cost.) Employees _____% Dependents _____%

6. The requested effective date of this plan is _____, year _____.

EDT reserves the right to reject any request to change the effective date of this Dental Plan if the request is not received within 10 days of this requested effective date.

7. Plan (must select one): Two Star Three Star

Traditional Plan: **Enhanced Plan**:** **MAC Plan**:** (See Sales Guide for information and rating on these plans)

Annual Maximum: \$750 \$1,000 \$1,500 \$2,000 (10+ Enrolled only)

U&C Out-of-Network for Traditional and Enhanced Plans: 80th Percentile (Standard) 90th Percentile (rate load applies)

Starter Plan: Yes (No Major services)

Deductible Choice: \$25 \$50 \$100 **Deductible waived for preventive:** Yes / No

Orthodontia: Yes No (minimum 5+ enrolled employees) Adult Orthodontia (10+ Enrolled only)

\$1,000 \$1,500 (10+ Enrolled only)

8. Is coverage applied for replacing other group dental insurance? Yes No

If yes, state: Type of Cvr. _____ Carrier _____ Term. Date _____

9. Rate Guarantee: 1 year standard 2 year option - contact Home Office (rate load applies)

10. Premium Deposit (One month required): \$ _____

11. Retired Employees: Covered (rate load applies) NOT Covered

Retiree class description _____

12. Remarks: _____

****Enhanced Plans not available in TX or MS. MAC Plans not available in NJ or MA.
Enhanced Starter Plans not available in MA.**



REQUEST FOR PARTICIPATION

INSTRUMENT OF ADOPTION AND REQUEST FOR PARTICIPATION IN
EMPLOYERS DENTAL TRUST (EDT)
Underwritten by Ameritas Life Insurance Corp., a UNIFI Company

THE UNDERSIGNED Employer (hereafter “the Employer”) hereby requests that it be approved as a Participating Employer under the above referenced Trust and accepts and agrees to be bound by all the terms and conditions of the restated and amended Trust Agreement dated August 1, 2006, and as amended thereafter.

The Employer hereby agrees to the appointments of First County Bank, a Connecticut chartered banking corporation, with offices at 100 Prospect Street, North Tower, 3rd Floor, Stamford, CT 06901, as Trustee, and National Employee Benefit Companies, Inc. of 16 International Way, Warwick, RI 02886 as the Administrator. The Administrator will be paid a billing administration fee by the Employer. Such fee is presently eighteen (\$18) dollars per month and may change in the future at the discretion of the Administrator with prior written notice to the Employer.

The Employer requests that insurance be made available to all of its eligible employees pursuant to the Group Insurance Policy or Policies issued to the Trust and in accordance with the Group Insurance application which is attached hereto. The Employer agrees to be bound by all the terms and conditions of such Group Insurance Policy or Policies issued by Ameritas Life Insurance Corp., a UNIFI Company. The Employer represents that it has been offered the opportunity to enroll all of its eligible employees and agrees to make this opportunity available to newly eligible employees. The Employer agrees to remit the required premiums as they become due to Ameritas.

The Employer hereby acknowledges that neither the Administrator nor the Trustee shall be liable for the payment of claims under the plan, nor shall they be held liable for any obligations of the Employer to pay the required premiums or to provide any benefits under the plan. The Employer further acknowledges that National Employee Benefit Companies, Inc. and/or its affiliate receives compensation for certain administrative services which it performs regarding the Group Insurance Policy or Policies. Furthermore, the agent who sells the Group Policy or Policies, or its affiliate, will receive a sales commission on such Group Policy or Policies from EDT. The undersigned Employer further agrees that it shall serve as the Plan Sponsor and named fiduciary of this benefit plan.

I certify, as the Employer, that to the best of my knowledge and belief all forgoing statements and answers are true.

Dated at _____, this _____ day of _____, 20 _____

Legal Name of Employer Applicant _____

Name of Officer, Partner or Proprietor (PRINT) _____

Signature of Officer, Partner or Proprietor _____

Producer Name (PRINT) _____ Producing Agent Signature _____

Administrator National Employee Benefit Companies, Inc. _____
(signature)