

**CIGNA DENTAL HEALTH
GROUP DENTAL PLAN
PRE-CONTRACT APPLICATION**

- CIGNA Dental Health Plan of Arizona, Inc.
- CIGNA Dental Health of California, Inc.
- CIGNA Dental Health of Colorado, Inc.
- CIGNA Dental Health of Delaware, Inc.
- CIGNA Dental Health of Florida, Inc.
- CIGNA Dental Health of Kansas, Inc.
- CIGNA Dental Health of Kansas, Inc. (Nebraska)
- CIGNA Dental Health of Kentucky, Inc.
- CIGNA Dental Health of Maryland, Inc.
- CIGNA Dental Health of North Carolina, Inc.
- CIGNA Dental Health of New Jersey, Inc.
- CIGNA Dental Health of New Mexico, Inc.
- CIGNA Dental Health of Ohio, Inc.
- CIGNA Dental Health of Pennsylvania, Inc.
- CIGNA Dental Health of Texas, Inc.

FILL IN EVERY LINE - Information must be completed by Applicant.

APPLICANT

- A. APPLICANT'S FULL LEGAL NAME: _____
- B. ADDRESS: _____ PHONE: _____
- C. BILLING ADDRESS, IF DIFFERENT: _____
- D. NAME OF CONTACT: _____ TITLE: _____
- E. THE APPLICANT IS: EMPLOYER LABOR UNION ASSOCIATION
- F. NATURE OF BUSINESS: _____
- G. PRIOR DENTAL COVERAGE: YES NO
- H. ERISA APPLIES: YES NO
- I. I.R.C. SECTION 125 APPLIES: YES NO

ELIGIBILITY

- A. TOTAL NO. OF EMPLOYEES: _____ TOTAL NUMBER OF ELIGIBLE EMPLOYEES: _____
- B. ALL CLASSES OF FULL-TIME EMPLOYEES WILL BE ELIGIBLE EXCEPT:
EXCLUDED CLASS(ES): _____
- C. CURRENT EMPLOYEES WILL BE ELIGIBLE UPON: _____ Months of Service or Other _____
- D. FUTURE EMPLOYEES WILL BE ELIGIBLE UPON: _____ Months of Service or Other _____
- E. AGE LIMITATIONS FOR DEPENDENTS: All unmarried children of Employees are eligible to enroll if (a) less than 19 years of age; or (b) full-time students less than 23 years of age. Please indicate changes, if any, applicable to: (a) _____ (b) _____

DENTAL PLAN

- A. EFFECTIVE DATE: The proposed Effective Date of group coverage is _____, or the first day of the month after which enrollment information and payment for the first month's coverage are received and accepted by CIGNA Dental Health. If this Pre-Contract Application is not accepted by CIGNA Dental Health, no coverage will become effective, and any premium advanced by the Applicant will be refunded. Employees who enroll after the Effective Date will be covered: as of the first day of the month after processing of enrollment by CIGNA Dental Health or Other _____.
- B. CONTRACT TERM: The initial term of the Group Contract shall extend from the Effective Date until the expiration of the initial premium guarantee period shown below. The Group Contract shall be automatically renewed on an annual basis in accordance with the Group Contract, unless terminated in accordance with the Group Contract.
- C. PREMIUMS: CIGNA Dental Health Premiums will be: 01- _____ 02- _____ 03- _____ 04- _____ Composite _____. Premiums are guaranteed through _____; however, premiums may be adjusted upon 30 days written notice* to the Group if, in CIGNA Dental Health's sole opinion, its liability (e.g., for taxes or benefits) is altered by any state or federal law.
- D. EMPLOYER CONTRIBUTION: Employee Only _____% Dependents _____. If no employer contribution, plan must be funded on a pre-tax basis under I.R.C. Section 125.
- E. PATIENT CHARGE SCHEDULE: _____. The Patient Charge Schedule of the Dental Plan is subject to annual change in accordance with the terms of the Group Contract. Please indicate expiration of guarantee period for the Patient Charge Schedule if other than one year from the Effective Date of coverage: _____.
- F. DENTAL OFFICE: Enrolled employees and their enrolled dependents must select a Dental Office. All family members must use the same Dental Office, or Each family member may select a different Dental Office.

*North Carolina Groups Only: North Carolina law requires 45-days' notice to group.

Applicant declares that he/she has read these statements and the answers to these questions are complete and true. Applicant agrees that: (1) this Pre-Contract Application is offered as an inducement for the group coverage applied for; (2) this Pre-Contract Application will form a part of any Group Contract issued; (3) no information given to or acquired by any representative of CIGNA Dental Health will bind CIGNA Dental Health unless it appears in writing on this Pre-Contract Application; and (4) no waiver or change will bind CIGNA Dental Health unless signed by an officer of CIGNA Dental Health. Group coverage will only be provided for persons eligible under the Group Contract issued.

APPLICANT: _____ TITLE: _____ AGENT/BROKER: _____
(PRINT NAME OF APPLICANT'S REPRESENTATIVE) (PRINT NAME)
 _____ DATE: _____
(SIGNATURE OF REPRESENTATIVE) (SIGNATURE OF AGENT/BROKER)

The following notice is required by Ohio and Kentucky Law:
 Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FLORIDA GROUPS ONLY:
 CDH advises the Applicant of the requirements of Florida Statutes, Section 627.8577.
 Any employer, group, or organization that pays or contributes to the premium of a group health insurance plan or a dental service plan corporation which provides dental coverage only upon the condition that services are rendered by an exclusive list of dentists or groups of dentists shall provide an alternative to enable the insured to have a free choice of dentist. The employer, group, or organization shall pay or contribute an equal dollar amount toward either alternative elected by the insured. The provisions of this section shall not require the commingling of costs and claims experience between the two alternative plans.

ACKNOWLEDGED: _____

Statement to be signed by Applicant upon payment of the premium or any part thereof

I HEREBY DECLARE that I have paid to _____ Agent _____ Dollars for which I hold his or her receipt bearing the same number as this Pre-Contract Application.

Date: _____ Applicant _____ No. _____

CIGNA DENTAL HEALTH No. _____

CONDITIONAL RECEIPT

Received of _____ / _____ Dollars to be applied against the first premium on the proposed Group Dental Plan under this Pre-Contract Application. This payment is made and accepted subject to the following conditions. Group coverage at CIGNA Dental Health rates applied for will take effect as of the Effective Date requested if the Pre-Contract Application is accepted at the CIGNA Dental Health Home Office. If certain persons eligible are to contribute to the cost of the Group Dental Plan, such Group coverage will take effect on the later of: the date the required number have enrolled, or on the Effective Date requested. If the Pre-Contract Application is not accepted, no coverage will become effective. Any premium payment advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.

Date: _____ Agent _____

Detach This Receipt When Payment is Made