COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
PO BOX 1365, COLUMBIA, SC 29202

# DENTAL INSURANCE APPLICATION FORM

☐ New Coverage ☐ Upgrade ☐ Dependent Addition Existing Policy No. _____
☐ Reinstatement ☐ Downgrade ☐ Rider Addition

## EMPLOYEE SECTION

| Proposed Insured Name (First, MI, Last) | Gender M ☐ F ☐ | Birthdate (mm/dd/yyyy) | Social Security No. |
|---|---|---|---|
| Home Address – Street City State Zip Code | | | |
| Email Address | | Home Phone No.<br>Business Phone No. | |
| Date Employed / Hrs. Worked/Wk / Section/Dept. No. / Job Title / Employee ID/Payroll No. | | | |
| Employer Name<br>RANKIN COUNTY SCHOOL DISTRICT | Employer Address (Street-City-State-Zip)<br>1220 APPLE PARK PL BRANDON MS 39042 | | |

## SPOUSE/DEPENDENT SECTION (complete if applying for spouse and/or dependent coverage)

| Name (First, MI, Last) | Gender | Birthdate (mm/dd/yyyy) | Relationship | Social Security No. |
|---|---|---|---|---|
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |

## ELIGIBILITY SECTION

1. Are you actively working? If "No" you are not eligible for any coverage. Yes ☐ No ☐

## REPLACEMENT SECTION

2a. Will any dental insurance with this or any other company be replaced or changed if the coverage applied for is issued? If yes, complete required replacement form if applicable in your state and complete 2b. Yes ☐ No ☐

2b. If replacing existing coverage, please indicate if existing coverage is Colonial Life & Accident Dental coverage or another carrier's Dental coverage by checking the appropriate box. ☐ Colonial Life & Accident Insurance Company ☐ Other

## PLAN SECTION

| Type of Coverage | Type of Change<br>**(N)** New<br>**(T)** Transfer<br>**(R)** Rider Addition | Policy Plan Code | Rider Plan Code | Tax Status<br>**(P)** pre-tax<br>**(A)** after tax | Monthly Premium |
|---|---|---|---|---|---|
| ☐ Individual<br>☐ Individual & Spouse<br>☐ Individual & Children<br>☐ Individual & Family | | | | P ☐<br>A ☐ | |

## OTHER SECTION

3. Do you have any existing dental coverage that will remain in force? If yes, please provide company name. _____ Yes ☐ No ☐

4. Are you Medicare eligible? Yes ☐ No ☐

5. Has the Important Notice to Persons on Medicare and the Guide to Health Insurance for People with Medicare been provided? Yes ☐ No ☐

## AGREEMENT SECTION

It has been explained and I understand that any coverage approved may be subject to waiting periods, exclusions and limitations as described in the policy.

I understand that this application will not be binding upon Colonial Life until both: 1) the policy is issued; and 2) the first premium is paid. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. I understand that any untrue statement or material misrepresentation may result in claim denial or rescission of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all premiums paid. I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I also understand that my payroll deduction amount will change if my coverage or premium changes.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the coverage indicated, I hereby request cancellation of my Colonial Life Policy Number(s) _____. Transfer or cancellation of the base plan will also mean cancellation of all attached riders. If for any reason the coverage applied for above is not issued, this request for cancellation shall be null and void.

**This policy provides dental and/or vision benefits only. Review your policy and any applicable riders carefully.**

Signed at: City BRANDON State MS Zip Code 39042 Date _____
mm/dd/yyyy

(x)_____
Signature of Proposed Insured (if applicable)

## AGENT SECTION

Agent's Name (If Present): _____
(please print)

Do you have knowledge or reason to believe that the Proposed Insured is intending to replace any existing dental insurance? Yes ☐ No ☐

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to waiting periods and limitations, if applicable. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I have not made, nor agreed to make, any rebate of premium for insurance. I further certify that I am a licensed agent in the state where this application is being taken.

Date_____ (x)_____ License No._____ Code No._____
mm/dd/yyyy Signature of Licensed Agent