AIG Employee Choice Dental
Master Application for Employee Benefits

AIG AMERICAN GENERAL

GOLDEN WEST DENTAL & VISION · compbenefits · DOMINION DENTAL · BETA HEALTH ASSOCIATION, INC. · TDA Total Dental Administrators, Inc. · Healthplex

AIG Life Insurance Company*
Wilmington, Delaware
A member company of American International Group, Inc.
Administrative Office: 3600 Route 66, P.O. Box 1591, MSN 3D, Neptune, NJ 07754-1591

*This company does not solicit business in New York.

Important Notice

The Company's group underwriting rules will be used to determine whether the applicant, if accepted, will participate in a Trust, or will be issued a group policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

Applicant Data (A group proposal is required as part of this application)

1. Full Name of Applicant (Company): _____

2. Group Contact Name: _____ Decision Maker: _____

3. Street Address: _____

   City: _____ State: _____ Zip: _____ Telephone: (____) _____

   Mailing Address (if different) _____ Fax: (____) _____

   City: _____ State: _____ Zip: _____

   E-Mail Address: _____ SIC Code: _____

4. Applicant is a: ❑ Proprietorship ❑ Partnership ❑ Corporation ❑ Union

   ❑ Other (Explain): _____

5. Nature of Business: _____

6. Are the employees of any affiliated or subsidiary companies or any other locations to be covered? ❑ Yes ❑ No
   If yes, give details below. If more space is needed, attach a separate sheet.

Name of Company	*Nature of Business*	*Full Address*	*# of Full-Time Employees*

7. Have you ever applied for, or been insured for, group insurance with any member company of AIG Inc., including United States Life? ❑ Yes ❑ No
   If yes, give details: Group Policy Number(s) _____
   Date Insurance Ended/Declined _____ Effective Date (if still insured) _____

8. Please complete the information below for those coverages being replaced:

Current Coverage Employer		*Voluntary*		*Replacing with the Company's Plans?**	*Prior Plan Name & Effective Date*	*Proposed Termination Date*
Life**	❑	Life**	❑	❑ Yes ❑ No		
Dental	❑	Dental	❑	❑ Yes ❑ No		
Vision	❑	Vision	❑	❑ Yes ❑ No		
STD	❑	STD	❑	❑ Yes ❑ No		
LTD	❑	LTD	❑	❑ Yes ❑ No		

* **Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).**

** Are there other Group Life Insurance plans in force which you are not replacing or currently applying for with another carrier? ❑ Yes ❑ No If yes, please indicate the highest benefit amount of each plan.

_____

_____

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the Company plan may not take effect until the day after the existing insurance is terminated.

For Home Office Use Only	Group Number:	Division Number: _____

Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least * 30 hours (20 hours for Voluntary Life only) per week, or _____ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.

9. Do you want to exclude any classes of full-time employees from coverage? ❑ Yes ❑ No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** _____

_____Total # of excluded employees _____

* Amount of hours may vary by state law.

Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

10. Waiting Period: Present Employees ❑ _____months OR ❑ First of the month following _____months*

Future Employees ❑ _____months OR ❑ First of the month following _____months*

*Only option available for Voluntary Coverages. Available on Group coverages with the 1st of the month effective date only.

11. a. Number of Full-Time Employees (Include employees not to be covered and those being continued) ..... _____

b. Number of Full-Time Employees **waiving all coverages** ..... _____

12. Do you employ 20 or more employees? (Include part-time, union, etc.) ❑ Yes ❑ No

Contribution Data – Not applicable to Voluntary Coverages

13. Will the employees be required to contribute toward the cost of the insurance? ❑ Yes ❑ No
If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.

Coverage	*Life/AD&D*	*Dep Life*	*EE Dental**	*Dep Dental**	*EE Vision**	*Dep Vision**	*STD*	*LTD*
Employer %								

****The employer must contribute a minimum of 35% of the total dental and vision premiums.***

Employee/Dependent Data

14. Are there any employees who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? ❑ **Yes** ❑ **No**
If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. **NOTE: This question does not need to be answered for Life and AD&D groups with more than 50 employees insured, Dental coverages, for Disability coverages with ten (10) or more employees insured, or for EXACT replacement coverage for 2-50 Life and AD&D and 2-9 Disability.**

Name of Employee	*Date Disability Began*	*Current Amount of Group Life Insurance In Force*	*Describe Nature of Injury/Sickness*	*Date Return To Full-Time Work*

Requested Effective Date

I request that the coverage(s) chosen take effect on:

❑ the date the application is approved in writing by the Company; or

❑ _____ If the application is approved in writing by the Company, this will be the Effective Date, which may not be changed.

For Employer Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included. For Voluntary Plans, the effective date must be the first of the month.

Applicant's Declaration

1. I verify that all employees applying for coverage are actively at work and working at least *30 hours per week, unless another minimum work requirement was authorized by the Company, and all employees meet the eligibility requirements as listed on the application.
2. I verify that the Company's benefit plan(s) have been offered to all employees. Completed waivers are attached for those employees and dependents electing not to participate in the plan(s).
3. To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
4. The agent(s) appointed for this application is (are):_____.
5. I understand that this application may be an application to participate in a Trust, as determined by the underwriting rules of the Company. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund. A copy of the Trust Policy will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Policy.
6. I understand and agree that:
   - no agent may change or waive any of the provisions of this application or of any plan of insurance;
   - any change or waiver may be made only by an officer of the Company; and
   - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
   - If the insurance contract compromises a part of an employee benefit plan, the Company is granted **sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.
7. It is understood and agreed that the group employer will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, and that the Company may rely on this information in adjudicating any claim under the policy.

_____

DATE *PRINT NAME OF OFFICER, PARTNER, PROPRIETOR*

_____

WITNESS *SIGNATURE OF OFFICER, PARTNER, OR PROPRIETOR*

_____

* Amount of hours may vary by state law ** May not be applicable in all states, and may vary by state law.

The Policyholder/Participant Employer hereby agrees to accept certificates in electronic format for delivery to persons covered under a group policy issued by the Company.

Note: *If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.*

Producing Agent's Declaration

Please Print PRODUCING AGENT		
Producer #	**Tax ID # / SS #**	**% Commissions split with other agents**
Name ***As Licensed***		**License #**
Mailing Address		
City/State/Zip		
Phone	Fax	E-Mail
Signature	***Date***	***City and State Where Signed***

Please Print GENERAL AGENT		
General Agent #	**Name:**	**Tax ID # / SS #**
Phone	Fax	E-Mail

HOME OFFICE USE ONLY

Policy No.	**Premium Deposit $**	**Underwriter**
Mode	**Coverages**	
Group Contact	**Producer**	**GA**