



1. GENERAL INFORMATION

Company Name: _____

Type of Entity: Sole Ownership Partnership Corporation Other

Street: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Nature of Business: _____ Sic Code Number: _____

Contact Person: _____ Number of years in business: _____

Requested Effective Date: _____ 1st, 200____. I recognize I should not cancel any existing coverage until I am notified of approval as a National Group Trust participant.

2. PLAN SELECTION

<p>Dental Health Services DHMO (Prepaid) Plan</p> <p><input type="checkbox"/> Gold Plan <input type="checkbox"/> Silver Plan <input type="checkbox"/> Bronze Plan</p> <p>Security Life Insurance Company Group PPO Dental</p> <p><input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3</p> <p><input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C</p> <p>Orthodontia</p> <p><input type="checkbox"/> DHS Panel Ortho <input type="checkbox"/> SLICA Indemnity \$1000 Ortho</p> <p>Vision Plan of America (VPA)</p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Vision Buy-up (B)</p> <p><input type="checkbox"/> Employer Paid (\$100 Frame Allowance)</p> <p><input type="checkbox"/> Voluntary (\$80 Frame Allowance)</p> <p><input type="checkbox"/> Voluntary(\$100 Frame Allowance)</p>	<p>Probationary Period for New Employees (select one)</p> <p>1st of the month following:</p> <p><input type="checkbox"/> Date of hire <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months</p> <p><input type="checkbox"/> 3 months <input type="checkbox"/> 6 months</p> <p>Prior Coverage</p> <p>Does your company have prior coverage</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes", please provide a copy of the prior carrier's bill and benefits booklet.</p>
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3. ENROLLMENT CERTIFICATION

<p>1. I certify that all full-time employees including owners are eligible to participate, except the following job classifications: (Please describe, or enter "none") _____</p> <p>2. Will you offer coverage for Domestic Partners? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. I certify that the following personnel data is true and complete:</p> <p>a. Total number of personnel on payroll _____</p> <p>b. Less number of ineligible employees* (-) _____</p> <p>c. Total number of eligible employees (=) _____</p> <p>d. # of employees with eligible dependents _____</p>	<p>e. The Employer pays the following portion of the monthly premium:</p> <p>Dental HMO (Employer must contribute at least 75% of the "Employee Only" dental HMO prepayment fee)</p> <p>Employee coverage _____% Dependent coverage _____%</p> <p>Fee-For-Service (Employer must contribute at least 75% of the "Employee Only" dental HMO premium. N/A for voluntary plans.)</p> <p>Employee coverage _____% Dependent coverage _____%</p>
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* Describe ineligible employees: _____

4. SIGNATURE

TO THE TRUSTEE OF THE NATIONAL GROUP TRUST: The undersigned hereby requests the Trustees of the National Group Trust to enroll our firm as a participating employer in said Trust dated the 22nd of September, 1988, as amended, and subscribes and agrees to be bound by the terms and conditions of said Trust. A copy of said Trust will be provided on written request. The undersigned agrees that the Trustee is merely a holder of the Master Policy, whose only responsibility is to see that certificates are issued to participating employees and to collect premiums, seeking and keeping in force any group insurance policies is an accommodation only. The premium includes a management allowance not to exceed 7%. The insurance agreement and all claims arising thereunder are solely between the undersigned and the insurance carrier. The undersigned employer-fiduciary understands that the independent agent or broker transacting this business will receive a commission. The undersigned employer-fiduciary approves the transaction and acknowledges receipt of a copy of this form.

Date: ___/___/___ Executed By: _____ Title: _____
(Owner, Partner, or Corporate Officer)



6. AGENT STATEMENT

Agent Name: _____ Agency Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email Address: _____
Pay Commissions: to me to my agency Insurance License #: _____
Taxpayer ID#: _____ Is taxpayer a corporation Yes No
I am currently appointed by Dental Health Services (DHS) Yes No (if "No" please complete licensing forms)
I am currently appointed by Security Life Insurance Company of America (SLICA) Yes No (if "No" please complete licensing forms)
Agent Number DHS: _____ Agent Number SLICA: _____
(I understand I must be appointed before I can receive commissions)

Effective Date of Rate Sheet: _____

I hereby certify that all information contained on this application is correct to the best of my knowledge. I have complied with the underwriting standards, and I have explained the coverage and Plan provisions in detail to the applicant firm. To the best of my knowledge, the firm is a favorable and stable prospect.

Dated: _____ Agent Signature: _____

**GENERAL AGENT
NAME AND NUMBER**

TripleChoicePlan

7. CHECKLIST FOR CASE SUBMISSIONS

- 1. Each employee must submit a complete enrollment card, dated and signed.
- 2. If the employee is waiving coverage for themselves or their dependents, they must complete the waiver portion of the employee application.
- 3. For non-voluntary plans, a current quarter DE6 (Employer's quarterly wage and withholding report) must be submitted with all enrollment material.
- 4. Groups submitted after the 20th of the month for the following month effective date must complete the New Group Acknowledgement form.
- 5. For non-voluntary groups with 10 or more enrolling employees, please submit a copy of the prior carrier's bill and benefit booklet.
- 6. Submit a payment for the first month's coverage plus administrative fee. Please make check payable to "TripleChoicePlan".
- 7. Mail enrollment materials to: TripleChoicePlan, 1964 Westwood Blvd., #420, Los Angeles, CA 90025

Please make check payable to "TripleChoicePlan".

Coverage By:

- Dental HMO benefits provided by Dental Health Services
- Vision HMO benefits provided by Vision Plan of America
- Indemnity/PPO Plan Dental and Indemnity Vision are underwritten by Security Life Insurance Company of America, Minnetonka, MN, under Policy GH-893

Indemnity/PPO Dental & Vision
Coverage Administered by:

Kelsey National Corporation

3030 South Bundy Dr., Los Angeles, CA 90066
(800) 366-5656 - (310) 390-1000 - FAX (310) 397-2934