TDA

Dental · Life · Disability · Vision

Application for Group Dental Coverage

Submit Application to Your Local TDA Office:

TDA - Arizona
2800 North 44th St, Suite 500
Phoenix, AZ 85008
(602) 266-1995, (888) 422-1995

TDA - Utah
6985 Union Park Center, Suite 675
Salt Lake City, UT 84047
(801) 268-9873, (800) 880-3536

Application is made to Companion Life Insurance Company for a Dental Policy, the provisions of which shall be made available to all eligible classes of Employees.

GENERAL INFORMATION

1. APPLICATION FOR DENTAL

a. Type of coverage(s): ☐ PPO ■ PPO/MAC ☐ EPO ☐ Elite Choice ☐ Other (Specify) _____

b. Term of Contract: ■ One Year ☐ Two Year ☐ Other (Specify) _____

c. Requested effective date: 1/1/2020
(Mo.) (Day) (Year)

2. EMPLOYER

a. Full legal name: Central Utah Telephone Inc dba Centracom Interactive

b. ☐ Corporation ☐ Proprietorship ☐ Partnership

c. Contact Person: Casey Cox (E-mail) c.cox@centracom.com

d. Employer Identification Number (EIN): 87-0258063

e. Primary business address in state policy is issued:
35 S State St, Fairview UT 84629
(Street) (City) (State) (Zip)

f. Billing address (if different than above):
(Street) (City) (State) (Zip)

g. Telephone Number: (435) - 427 - 3331

h. Nature of Business: Telecommunication Services SIC Code: 4813

i. Affiliates or subsidiaries to be covered (use "Additional Information on page 4 for this if more space is needed):

(Full Legal Name) (Full Legal Name)

(Street Address) (Street Address)

(City, State, Zip) (City, State, Zip)

(Nature of Business) (Nature of Business)

j. Number of eligible employees residing outside of the state in which the policy was issued:
NV 3
(State and number of employees) (State and number of employees)

(State and number of employees) (State and number of employees)

3. **OTHER COVERAGE INFORMATION**

a. Will this coverage supplement other Dental coverage? ☐ Yes ■ No
If yes, what other coverage will be provided? _____

b. Will alternative coverage through a DHMO or other capitation plan be offered? ☐ Yes ■ No
If yes, show name of capitation plan. _____

c. Will this coverage replace a current program? ■ Yes ☐ No
If yes, who is the current carrier? Aetna

ELIGIBILITY

1. **CLASSES OF ELIGIBLE EMPLOYEES**

a. Active employees

◆ All active full-time employees (A full-time employee must work 30 hours per week of compensable time.)

◆ Specific class or class's only (Specify class, such as hourly, salaried, covered or not covered by collective bargaining, etc.): **All Others: First of the Month following 60 Days.**
"Management" Class Waiting Period "First of the Month Following Date of Hire"

b. Other - Explain if there are any persons who will be enrolled who are not actively employed: i.e., retirees, COBRA, etc.: _____

2. **NUMBER OF ELIGIBLE EMPLOYEES IN ELIGIBLE CLASSES**

a. Total number of employees on the payroll		119
b. Less number of employees not eligible		
1) Temporary or seasonal employees	( )	
2) Employees working less than 30 hours per week	( )	
3) Employees serving probationary period	( )	
4) Employees enrolled in a DMO or Capitation plan	( )	
5) Total ineligible employees		( )
c. Net eligible employees (a minus b.5)		( )
d. Number of eligible employees who will not be enrolled. Specify Reason: _____		( )
e. Number of eligible employees who will be enrolled. (c minus d)		113

**A $10.00 per month administration fee will be charge for groups with less than 25 enrolled*

3. **DEPENDENT ELIGIBILITY**

Spouse and/or unmarried children to age 19 or to age 26 if unmarried. If there are any additional eligibility requirements for dependents, please specify:

_____

4. **ENROLLMENT**

To enroll, timely application must be made to Companion Life Insurance Company. Eligible employees must submit a completed application card to the Employer within 30 days following completion of a: Specify amount (60) day probationary period. (Example 0, 30, 60, 90)

Application for addition of newly acquired eligible dependents through marriage must be submitted to Companion Life Insurance Company, through the Employer, within 30 days of marriage.

Application for continuation of coverage for newborn children of the insured employee and spouse and/or newly acquired adopted children must be submitted within 60 days of the date of birth of the natural child or within 60 days of placement for adoption in the employee's home of a child which is to be adopted.

NOTE: ELIGIBLE employees or their dependents who do not enroll when they first become eligible may make application for enrollment only during the group' annual open enrollment period unless the Employer is contributing 100 percent of the cost of the individual coverage (see "Employer's Contributions" below) and has agreed or is required to make retroactive payment of premium charges.

EMPLOYERS CONRIBUTIONS

1. PERCENT OR AMOUNT

The Employer agrees to make the following contribution toward the cost of the employee and dependent coverage:

Employee	100	%
Dependent	100	%

2. RETROACTIVE COVERAGE

If the Employer pays 100% of employee and/or dependent coverage, eligible individuals who did not enroll when first eligible will have retroactive coverage from the date of first eligibility upon payment of retroactive premium.

☒ Yes ☐ No

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PLAN 1 DESCRIPTION

1. **PLAN NAME AND TYPE:** High (Example High, Low) ☐ PPO ■ PPO/MAC ☐ EPO ☐ Elite Choice ☐ Other _____

■ Plan A - Endodontics and Periodontal Services as Class II Benefits
☐ Plan B - Endodontics and Periodontal Services as Class III Benefits
☐ Custom -

Basic Endodontics (Root Canals)	Class _____
Major Endodontics	Class _____
Periodontics	Class _____
Simple Extractions	Class _____
Surgical Extractions	Class _____
Implants	Class III

DEDUCTIBLE

Waived for Class I ■ Yes ☐ No
Per person: $ 50
Per Family $ 150

MAXIMUM BENEFIT PER YEAR

Per Person $ 1500
Per Calendar Year for all Covered Dental Benefits - (Class I, II, and Class III)

THE POLICY WILL PAY - "IN-NETWORK"

Class I:	Preventative	100 %
Class II:	Basic	100 %
Class III:	Major	60 %

THE POLICY WILL PAY - "OUT-OF-NETWORK" of the Allowable Fee*

Class I:	Preventative	100 %
Class II:	Basic	80 %
Class III:	Major	50 %

Twelve (12) Month Waiting Period Apply to Class III? ☐ Yes ■ No
Credit given for time covered under this employer's prior Plan? ☐ Yes ☐ No ■ N/A

Class IV: Ortho** 50 %

Twelve (12) Month Waiting Period Apply to Class IV? ☐ Yes ■ No
Credit given for time covered under this employer's prior Plan? ☐ Yes ☐ No ■ N/A
Adult Ortho Included? ■ Yes ☐ No

The Orthodontic Lifetime Maximum (if applicable): $ 1500

ADDITIONAL CONTRACT MODIFICATIONS: _____

PREMIUMS AGREED TO

Dental Plan 1 PPO/MAC **Plan Name** _____

Option 1. **2 - Tier** ☐ **3 - Tier** ■ **4 - Tier** ☐

Employee	Employee	Employee	24.11 per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	57.34 per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	98.73 per month
		Family(Emp. +3 or more)	_____ per month

Dental Plan 2 _____ **Plan Name** _____

Option 2. **2 - Tier** ☐ **3 - Tier** ☐ **4 - Tier** ☐

Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month

Dental Plan 3 _____ **Plan Name** _____

Option 3. **2 - Tier** ☐ **3 - Tier** ☐ **4 - Tier** ☐

Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month

Dental Plan 4 _____ **Plan Name** _____

Option 4. **2 - Tier** ☐ **3 - Tier** ☐ **4 - Tier** ☐

Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month

Vision Plan _____ *(if applicable)*

Vision. **2 - Tier** ☐ **3 - Tier** ☐ **4 - Tier** ☐

Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month

1. Initial amount submitted with this Application $ _____
Please attach a copy of the initial Census.

ADDITIONAL INFORMATION

2. Agreement

a. This application is signed by a person or persons authorized by the Employer to make such an agreement; and
b. The application is received an approved by the Companion Life Insurance Company (TDA) at its home office; and
c. The initial month's premium is received by Companion Life Insurance Company (TDA).

This application will become part of the Group Dental Policy issued to the Employer. Coverage is effective on the first billing due date after the conditions in (a), (b), and (c) above have been met. Coverage is subject to all the terms and conditions of the Group Dental Policy.

3. Signatures

For a corporation, the President or Vice President and the Secretary or Acting Secretary should sign. For a proprietorship, the owner should sign. For a partnership, any partner should sign.

I have read this application, agreed to the terms, and certify that all statements are true and complete. It is understood that provisions of the Group Dental Policy, including premiums therefore, may be amended or changed from time to time, upon written notice from Companion Life Insurance Company (TDA) to the Employer.

By Casey Cox
(print name)

(sign name)

Title Vice President

Date 12/20/19

Witnessed by:

Lesa A. Cox
(print agent's name)

By Lesa A. Cox
(sign agent's name)

Date 12/20/19

General Agent (if applicable):

_____
(print agent's name)

By _____
(sign agent's name)

Date _____