

Southland National Insurance Corporation

Group Dental Insurance Master Application

P.O. Box 1520, Tuscaloosa, AL 35403-1520 T: 1-866-839-5308 F: 1-205-343-1239

Group No. _____ Effective Date _____

Company Name _____ SIC Code _____

Mailing Address _____

Physical Address (If Different) _____

City _____ State _____ Zip _____

Contact for Billing and Eligibility _____

Email Address _____ Telephone (____) _____ Fax (____) _____

Participation Requirements:

Number of Employees: _____ Number of Eligible: _____ Number of Enrolled: _____

Group Type: Voluntary Contributory Employer Paid

Plan Type: Dental (Buy Up Plan) Dental (Base Plan)

Eligibility: Waiting Period for New Subscribers * _____

*(All eligible subscribers become effective on the first of the month following the waiting period.)

Please send Member and Enrollment Materials to (CHECK ONE):

- Group - Attn: _____
 Subscriber
 Broker/Agent

NOTE: First month's premium must be sent in with the enrollment forms.

Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan. I understand and agree if, on the effective date, an employee is not in permanent full-time active work or unable to perform usual and customary duties, coverage will not be effective until the employee returns to an active eligible status. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.

I hereby authorize Southland National Insurance Corporation to issue a Group Policy Agreement and Certificates for coverage as shown above. The effective date of these coverages shall be as shown above, provided that final data submitted is satisfactory for the issuance of the Policy requested. I agree to administer the programs as described in the attached Policy Agreement and to make payroll deductions if applicable.

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.

Authorized Signature _____

Title _____ Date _____

Agent/Broker Signature _____ Date _____

SOUTHLAND NATIONAL INSURANCE CORPORATION

By: _____