

# 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: \_\_\_\_\_

**SNIC-GDA2008**