UNITED CONCORDIA

APPLICATION FOR GROUP VISION INSURANCE FROM UNITED CONCORDIA INSURANCE COMPANY

GROUP'S LEGAL NAME AND ADDRESS:

Name: _____ Address: _____

_____

For general correspondence, receipt of billings and certificates: (If address is different than noted, place contact address on back)

Policymaker Name: _____ Title: _____

Address: _____

Phone #: _____ Fax #: _____ Email: _____

Group Administrator: _____ Marketing Relationship: _____

Phone #: _____ Fax #: _____

In order for application to be complete, please attach quote/proposal/rate card with product and rates marked.

PARTICIPATION SUMMARY:

_____ # Eligible employees

_____ # Enrolled

_____ # Waived

_____ # Spouse Opt-Outs

GROUP EFFECTIVE DATE:

(1st of month) _____/_____/_____

PRIOR COVERAGE: Yes ☐ No ☐

Carrier _____

RATE PERIOD: (MM/DD/YYYY)

From _____ 12:00 AM
(1st of month)

To _____11:59 PM
(Last day of month)

ELIGIBILITY WAITING PERIOD:

New Certificate Holders are eligible for coverage on the _____ of the month following _____ days/mos in an eligible class, or other: _____

_____

_____

_____.

COVERAGE INCLUDES:

☐ Employee
☐ Spouse/Domestic Partner
☐ Children to Age 26

THE APPLICANT REPRESENTS that: by signing this application, he/she agrees that the group dental insurance described above will become effective upon acceptance of this application by United Concordia (UC). Application will be returned if quote is not attached. Applicant further acknowledges that no coverage will be effective before the date determined by UC and only if the first Premium has been paid and underwriting bid qualifications are met. UC does not refund premium on a pro-rata basis. If this application is accepted, it becomes a part of the insurance contract between Applicant and UC. If this application is not accepted, any Premium advanced by the Applicant will be refunded. Applicant states to the best of his/her knowledge or belief, that all information on this application is true and complete, and acknowledges that coverage may be rescinded (after UC provides 30 days' notice) if there is fraud or intentional misrepresentations of material fact on this application. Under CA law after 24 months following the issuance of a health insurance policy, UC shall not rescind the policy for any reason, and shall not cancel the policy, limit any of the provisions of the policy, or raise premiums on the policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. Upon policy renewal date, payment of the renewal premium will confirm acceptance of that renewal for the subsequent rate period. No agent or broker has the right to accept this application or bind coverage. Any first premium or application submitted to UC or its sales personnel by a non-appointed producer must be accompanied by completed appointment paperwork or it will be returned to the non-appointed producer.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicant Signature: _____ Date:_____

Title: _____

AGENT: To the best of his/her knowledge, the information on this application is complete and accurate. He/she has explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant has understood the explanation. The agent signing this attestation is aware that he/she shall be subject to a civil penalty of up to $10,000 if he/she willfully states as true any material fact that he/she knows to be false.

Producer: _____ UCD Producer ID #: _____

Agent: _____ UCD Agency ID #: _____

Policies underwritten by United Concordia Insurance Company.

Notice: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.