

**APPLICATION FORM FOR  
DENTAL INSURANCE WITH OPTIONAL RIDERS**

**TIME INSURANCE COMPANY**

**PLEASE PRINT IN BLACK INK**

**TYPE OF ACTIVITY**

New       Change       Conversion       Reinstatement      Policy Number \_\_\_\_\_

**PERSON(S) PROPOSED TO BE INSURED**

Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Social Security #
(Applicant)					
(Spouse)					

**Dependents**

Relationship	Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Full time student
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Resident Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Best Time to Call \_\_\_\_\_

Name of Employer \_\_\_\_\_ Type of Business \_\_\_\_\_

Job Title \_\_\_\_\_

Job Duties \_\_\_\_\_

**PROPOSED ADDITIONS TO AN EXISTING POLICY ONLY**

Add Spouse named above       Add Dependent(s) named above

Reason(s) for addition(s) \_\_\_\_\_

Desired effective date for addition(s): \_\_\_\_\_

Complete the POLICY INFORMATION section below to indicate the type of coverage now desired. Complete the remainder of the application respective to any coverage applicable to the proposed addition.

**BILLING – to be completed by agent**

**Payroll Deduction**

Monthly       28 day  
 Other \_\_\_\_\_

**Direct**

Monthly Credit Card       Monthly EFT (Electronic Fund Transfer)  
 Annual Billing

Employee No. \_\_\_\_\_ Dept. No. \_\_\_\_\_

Billable Premium \$ \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_

Sit. Code \_\_\_\_\_

**POLICY INFORMATION - to be completed by agent**

**CHECK COVERAGE DESIRED**

- Individual .....  and \_\_\_\_\_ Dependent Child(ren)  
*number of*
- Individual & Spouse ...  and \_\_\_\_\_ Dependent Child(ren)  
*number of*

Occupation Class \_\_\_\_\_  
 Industry Code \_\_\_\_\_  
 Industry Class A B C D E

	Type 2 & 3 Annual Maximum	Region*	Modal Premium	If Payroll Deduction
<input type="checkbox"/> \$25 Wellness – Level 1 Base Policy	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$ 750 <input type="checkbox"/> \$1,000	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	\$	<input type="checkbox"/> Pre Tax <input type="checkbox"/> After Tax
<input type="checkbox"/> \$50 Wellness – Level 2 Base Policy	<input type="checkbox"/> \$ 750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250			
<input type="checkbox"/> \$75 Wellness – Level 3 Base Policy	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250 <input type="checkbox"/> \$1,500			
<input type="checkbox"/> Orthodontic Rider			\$	
<input type="checkbox"/> Inflation Rider			\$	After tax only
<b>*NOTE:</b> Region selection may be resident region or any lesser region only.			\$	<b>TOTAL PREMIUM</b>

**INSURANCE HISTORY**

Is this coverage intended to replace any Dental coverage now in force? .....  Yes  No

If "Yes", provide the following information about your current insurer:

Name of Insurer \_\_\_\_\_ Policy Number \_\_\_\_\_

Phone Number (      ) \_\_\_\_\_

**PROPOSED POLICYOWNER'S AGREEMENT**

I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. The application form and any amendments shall be the basis for the contract. I also agree that:

The policy, if approved by Time Insurance Company, will have the Effective Date recorded on the Policy Schedule by Time Insurance Company. I acknowledge receiving the following, if required:

- Fair Credit Reporting Act Pre-Notification
- Outline of Coverage (if required by state law)
- the Abbreviated Notice of Insurance Information Practices

I understand that the premium amount listed on this application represents the premium amount that my employer will remit on my behalf if I select payroll deduction as the method of premium payment. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my agent.

I have read, or had read to me, the completed application and realize that policy issuance is based upon statements and answers provided and any other pertinent information that may be required for proper underwriting. The answers are complete and true to the best of my knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions in the policy.

A.M.  
 P.M.

\_\_\_\_\_  
Signature of proposed Policyowner

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Time Signed

\_\_\_\_\_  
City & State

**AGENT INFORMATION AND REVIEW**

Agency Name and Time Agency Number \_\_\_\_\_

Agent Name and Time Agent Number \_\_\_\_\_

Agent Phone Number (\_\_\_\_\_) \_\_\_\_\_ Agent Fax Number (\_\_\_\_\_) \_\_\_\_\_

General Agent is located in the state of \_\_\_\_\_

I certify that:

- I personally saw the applicant. The applicant was asked each required question and the answer truly and accurately recorded on the application in the respective response area. The answers are true to the best of my knowledge.
- The application was completed by the applicant or applicant's representative and the answers are true to the best of my knowledge.

\_\_\_\_\_  
Licensed Resident Agent's Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Initial here if you witnessed the signing of this form by the proposed Policyowner.

**FAIR CREDIT REPORTING ACT AND PRIVACY PRE-NOTIFICATION**

Thank you for considering Time Insurance Company as your insurance carrier. Your enrollment form will be processed as quickly as possible. Public Law 91-508 and state privacy acts require that we advise you that an investigative consumer report may be made in connection with this application form which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through telephone or personal interviews with you, your friends, neighbors and associates. You may request an interview in connection with the preparation of the report. Upon written request, you are entitled to receive a copy of the report.

**ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

Information collected by us and used to issue an insurance policy or certificate may be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, PO Box 1739, Ft. Mill, SC 29716-1739.

**FRAUD WARNING**

Any person who, with intent to defraud or knowingly presents false information on an application for insurance, or files a false or fraudulent claim for payment of a loss or benefit, is guilty of insurance fraud. Any person found guilty of insurance fraud may be subject to fines and confinement in prison.