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DENTAL & VISION ADMINISTRATORS EMPLOYER AGREEMENT

(SMALL EMPLOYER GROUPS WHO ARE ELECTING DENTAL AND/OR VISION COVERAGE)

- I understand the pre-existing conditions limitations of the insurance plan, and understand that coverage is renewable at the option of the Underwriting Company.
- I understand the underwriting and participation requirements and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force. The Open Enrollment period shall be during group's 11th month of annual coverage.
- For the Vanguard Indemnity Plan and the PacifiCare Dental PPO Plan, I understand that there is a one-year waiting period for "Major" dental services. This waiting period will be waived for employees/dependents listed on the prior carrier's billing at the time of transfer to a PacifiCare Indemnity Dental or PPO plan. New hires are subject to a one-year waiting period for all "Major" dental services. "Major" dental services include crowns, dentures and bridges OR crowns, dentures, bridges, oral surgery, periodontics and endodontics.
- The Vanguard Indemnity, PacifiCare Dental PPO Plan and Vision PPO plans are underwritten by PacifiCare Life and Health Insurance Company.
- The Dental HMO Plans are offered by PacifiCare Dental.

For the Vanguard Indemnity plans only, please initial the following statement:

The undersigned employer hereby adopts and enrolls in the group insurance plan of the Vanguard Group Dental Trust and subscribes to the terms of the Trust agreement which established such Trust. It is understood that no coverage is in force until notice of approval has been furnished by the Trust Administrator and premium has been received by the Trust Administrator.

I further acknowledge and agree that no one other than the Trustees or a person designated in writing by the Trustees may accept this application on behalf of the Vanguard Group Dental Plan Trust, and that no agent or broker has the authority to change any provision of the master policy or of the Trust. _____ (Initials of authorized person)

I hereby certify that all of the information contained in the agreement and application is correct to the best of my knowledge. I have complied with the underwriting rules and have explained to the applicant in detail the coverages of this plan. Any exceptions are detailed here or on an additional sheet attached.

Signature of authorized person for employer _____ Date signed _____

Broker or General Agent signature _____ Date signed _____