

APPLICATION FOR ENROLLMENT OR CHANGE INSTRUCTIONS

To elect dental coverage, please fill out the attached form and return it to your Group Official.

APPLICANT INSTRUCTIONS

Complete the following information:

Box #1A - Dental Plan Options

- Check off Dental Plan

Box #4 - Coverage Requested

- Check off type of contract

Box #6 A. - Eligible Persons to be Enrolled

- Print last name, first name, middle initial, date of birth, sex, social security number for yourself and each dependent. *If dependent is over contract age, check off reason: student or handicapped.

B. Marital Status of Applicant

- Check off appropriate box

Box #7 - Applicant's Address and Phone Number

- Print complete address and phone number

Box #8 A - E - Other Group Dental Insurance

- Print other group dental insurance information if you or any member of your immediate family have other dental insurance.

Box #9 - For Presently Enrolled Customers

Changing Their Coverage

- Enter date of event: Month/Day/Year
- Enter identification number

9A - Adding Dependent(s)

9B - Deleting Dependent(s)

9C - Continuing Coverage under COBRA

- Complete data where applicable

Box #10 - Signature

- Please sign and date the application, return it to your Group Official to complete Sections 2, 3 and 5.

GROUP OFFICIAL INSTRUCTIONS

Complete the following information:

Box #1B - Insurer

- Check off name of Insurer providing benefits.

Box #2A - Group Name

- Print your company's name

2B - Group Number/Sub Group Number

- Enter 7-digit group number

2C - Proposed Effective Date

- Enter applicant's proposed effective date of coverage

2D - Remitting Agent's Signature and Date

- Please sign and date the application

Box #3 - Reason for Application

- Check off the appropriate box

Box #5 - Employment Information

5A - Date of Hire

- Enter month/day/year

5B - Date of Rehire

- Enter month/day/year

5C - Is employee actively at work?

- Enter appropriate information

NOTE: To avoid processing delay, please review the entire application for completeness.



Rayant Insurance Company of New York
A Horizon Company

NEW YORK APPLICATION FOR ENROLLMENT OR CHANGE

Send Correspondence to:
Rayant - Dental Programs
P.O. Box 1938
Newark, NJ 07101-1938
1-888-667-4547
www.rayant.com

1A DENTAL PLAN OPTION (Check one Box only) <input type="checkbox"/> Rayant Dental Option <input type="checkbox"/> Rayant Dental EPO <input type="checkbox"/> Rayant Dental PPO <input type="checkbox"/> Rayant Dental PPO Access	1B INSURER Rayant Insurance Company of New York	2 GROUP INFORMATION (Section to be completed by employer.)	
		A. Group Name	B. Group No. / Subgroup No.
		C. Proposed Effective Date	D. Remitting Agent's Signature and Date

3 REASON FOR APPLICATION Please check the appropriate box(es). <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other _____ <input type="checkbox"/> Rehire <input type="checkbox"/> COBRA	<input type="checkbox"/> Adding/Deleting Dependents <input type="checkbox"/> Newly Eligible	4 COVERAGE REQUESTED Please check the appropriate box <table border="1"> <tr> <th>Type of Contract</th> <th>Single</th> <th>Husband and Wife</th> <th>Family</th> <th>Parent and Child(ren)</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	Type of Contract	Single	Husband and Wife	Family	Parent and Child(ren)					
Type of Contract	Single	Husband and Wife	Family	Parent and Child(ren)								

5 EMPLOYMENT INFORMATION

A. Date of Hire: Mo. Day Yr. B. Date of Rehire: Mo. Day Yr.

C. Is the employee actively at work? If yes, indicate the number of hours worked per week _____
 yes no If no, check the appropriate box: Pensioner Disabled Other (specify) _____

6 ELIGIBLE PERSONS TO BE ENROLLED

A. Complete this box for yourself and all dependents enrolling. Attach another application if you have more than four children.
 (Note: Dependent children are covered under a parent's contract only until they reach contract termination age as specified in the group contract.)

LAST NAME	LAST NAME	MI	DATE OF BIRTH			SEX	FULL TIME STUDENT OVER CONTRACT AGE	HANDICAP OVER CONTRACT AGE	SOCIAL SECURITY NUMBER
			MO	DAY	YR	M/F			
Applicant									
Spouse/Domestic Partner									
Child							*	*	
Child							*	*	
Child							*	*	
Child							*	*	
Legal Ward									

* Verification is required for dependents over contract age for full time students and/or handicap.

B. MARITAL STATUS OF APPLICANT Single Married Divorced Widow(er)

7 APPLICANT'S ADDRESS AND PHONE NUMBER

Street _____ Area Code _____
 City _____ State _____ Zip Code _____

8 OTHER GROUP DENTAL INSURANCE (Please complete this if you or any member of your immediate family has other dental insurance.)

A. Name of Policy Holder (Last, First) _____ B. Policy or Identification Number _____

C. Name of other Insurance Company _____

D. Address of other Insurance Company _____

E. Name and Location (City, State) of Spouse's Employer _____

9 FOR PRESENTLY ENROLLED CUSTOMERS CHANGING THEIR COVERAGE (Check reason(s) for change and indicate the date of the event and ID number.)

DATE OF EVENT MO DAY YR IDENTIFICATION NO. _____
 COPY FROM YOUR ID CARD _____

A. ADDING DEPENDENT(S) (Be sure to complete section 6A.)
 Marriage Legal Ward Spouse's Coverage Terminated Child Adoption Previously Refused/Waived Coverage Other (specify) _____

B. DELETING DEPENDENT(S)
 Divorced/Separation Coverage Elsewhere Child Reached Termination Age or Married
 Death Entered Military Other (specify) _____
 Names of Dependents Being Deleted: _____
 Spouse Child(ren)

C. CONTINUING COVERAGE UNDER COBRA
 Spouse of Deceased Employee Divorced Reduction in hours/no longer meets Group's eligibility requirements Other (specify) _____
 Employment Terminated Disabled Dependent Child no longer eligible under terms of employer's health plan

10 SIGNATURE I hereby apply to the company identified in Section 1B ("Rayant Insurance Company of New York") on behalf of myself and any eligible dependents listed. I understand and agree that any coverage provided pursuant to this application will be at the level of benefits available through arrangements between Rayant Insurance Company of New York and my group. I hereby accept responsibility for payment of any portion of the premium, if applicable, which I have agreed to pay through the group. I further acknowledge that coverage shall become effective only if approved by Rayant Insurance Company of New York and such services which are rendered on or after the effective date of coverage. I authorize Rayant Insurance Company of New York to request information from providers to assist in claims processing and to accept claims submitted electronically by third parties. I certify to the best of my knowledge and belief the information on this application is complete and true. I understand that any claim by me or one of my eligible dependents may be denied and my coverage cancelled without prior written notice if I have included false information. I also understand that such a termination will be retroactive to the effective date of our coverage. Signature of Applicant _____ Date _____ FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.	FOR PLAN USE ONLY INPUT DATE AND INITIAL _____ VERIFY DATE AND INITIAL _____
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Rayant Insurance Company of New York

NEW YORK APPLICATION FOR ENROLLMENT OR CHANGE

Send Correspondence to: Rayant - Dental Programs P.O. Box 1938 Newark, NJ 07101-1938 1-888-667-4547 www.rayant.com

1A DENTAL PLAN OPTION (Check one Box only) 1B INSURER Rayant Insurance Company of New York 2 GROUP INFORMATION (Section to be completed by employer.) A. Group Name ABC Trucking Inc. B. Group No. / Subgroup No. M99 / 12345 C. Proposed Effective Date 1/1/95 D. Remitting Agent's Signature and Date 5/31/95

3 REASON FOR APPLICATION Please check the appropriate box(es). X New Hire Open Enrollment Other Adding/Deleting Dependents Newly Eligible 4 COVERAGE REQUESTED Please check the appropriate box Type of Contract Single Husband and Wife Family Parent and Child(ren) X

5 EMPLOYMENT INFORMATION A. Date of Hire: Mo. 10 Day 01 Yr. 95 B. Date of Rehire: Mo. Day Yr. C. Is the employee actively at work? X yes no If yes, indicate the number of hours worked per week If no, check the appropriate box: Pensioner Disabled Other (specify)

6 ELIGIBLE PERSONS TO BE ENROLLED A. Complete this box for yourself and all dependents enrolling. Attach another application if you have more than four children. (Note: Dependent children are covered under a parent's contract only until they reach contract termination age as specified in the group contract.) Table with columns: LAST NAME, MI, DATE OF BIRTH (MO, DAY, YR), SEX (M/F), FULL TIME STUDENT OVER CONTRACT AGE, HANDICAP OVER CONTRACT AGE, SOCIAL SECURITY NUMBER. Rows for Applicant (Doe), Spouse/Domestic Partner (Doe), Child (Doe), Child, Child, Child, Legal Ward.

* Verification is required for dependents over contract age for full time students and/or handicap. B. MARITAL STATUS OF APPLICANT Single Married X Divorced Widow(er)

7 APPLICANT'S ADDRESS AND PHONE NUMBER Street 5 Deer Trail Rd Area Code City Wildwood State NJ Zip Code 08260 6 0 9 - 5 5 5 - 8 7 6 5

8 OTHER GROUP DENTAL INSURANCE (Please complete this if you or any member of your immediate family has other dental insurance.) A. Name of Policy Holder (Last, First) Doe Jane B. Policy or Identification Number A 193486 C. Name of other Insurance Company Insurance Company USA D. Address of other Insurance Company 9 Vreeland Rd E. Name and Location (City, State) of Spouse's Employer Anytown, NJ 07110

9 FOR PRESENTLY ENROLLED CUSTOMERS CHANGING THEIR COVERAGE (Check reason(s) for change and indicate the date of the event and ID number.) DATE OF EVENT MO DAY YR IDENTIFICATION NO. COPY FROM YOUR ID CARD

A. ADDING DEPENDENT(S) (Be sure to complete section 6A.) Marriage Legal Ward Spouse's Coverage Terminated Child Adoption Previously Refused/Waived Coverage Other (specify) B. DELETING DEPENDENT(S) Divorced/Separation Coverage Elsewhere Child Reached Termination Age or Married Death Entered Military Other (specify) Names of Dependents Being Deleted: Spouse Child(ren) C. CONTINUING COVERAGE UNDER COBRA Spouse of Deceased Employee Divorced Reduction in hours/no longer meets Group's eligibility requirements Other (specify) Employment Terminated Disabled Dependent Child no longer eligible under terms of employer's health plan

10 SIGNATURE I hereby apply to the company identified in Section 1B ("Rayant Insurance Company of New York") on behalf of myself and any eligible dependents listed. I understand and agree that any coverage provided pursuant to this application will be at the level of benefits available through arrangements between Rayant Insurance Company of New York and my group. I hereby accept responsibility for payment of any portion of the premium, if applicable, which I have agreed to pay through the group. I further acknowledge that coverage shall become effective only if approved by Rayant Insurance Company of New York and such services which are rendered on or after the effective date of coverage. I authorize Rayant Insurance Company of New York to request information from providers to assist in claims processing and to accept claims submitted electronically by third parties. I certify to the best of my knowledge and belief the information on this application is complete and true. I understand that any claim by me or one of my eligible dependents may be denied and my coverage cancelled without prior written notice if I have included false information. I also understand that such a termination will be retroactive to the effective date of our coverage. Signature of Applicant Date 5/31/95 FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FOR PLAN USE ONLY INPUT DATE AND INITIAL VERIFY DATE AND INITIAL