



Rayant Insurance Company of Pennsylvania
A Horizon Company

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 Option

- Check off Dental Option

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 Pennsylvania
A Horizon Company

PENNSYLVANIA 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 Option Plus <input type="checkbox"/> Rayant Dental PPO <input type="checkbox"/> Rayant Dental PPO Access		1B INSURER Rayant Insurance Company of Pennsylvania		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"/> Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> Other _____ <input type="checkbox"/> Adding/Deleting Dependents <input type="checkbox"/> Newly Eligible			4 COVERAGE REQUESTED Please check the appropriate box Type of Contract: Single, Husband and Wife, Domestic Partners, 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 _____ <input type="checkbox"/> yes <input type="checkbox"/> no If no, check the appropriate box: <input type="checkbox"/> Pensioner <input type="checkbox"/> Disabled <input type="checkbox"/> 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		FIRST NAME		MI	DATE OF BIRTH MO DAY YR	SEX M/F	FULL TIME STUDENT OVER CONTRACT AGE	HANDICAP OVER CONTRACT AGE	SOCIAL SECURITY NUMBER	
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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Domestic Partner (Please attach proof of Domestic Partnership)										
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.) <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Ward <input type="checkbox"/> Spouse's Coverage Terminated <input type="checkbox"/> Child <input type="checkbox"/> Adoption <input type="checkbox"/> Previously Refused/Waived Coverage <input type="checkbox"/> Other (specify) _____										
B. DELETING DEPENDENT(S) <input type="checkbox"/> Divorced/Separation <input type="checkbox"/> Coverage Elsewhere <input type="checkbox"/> Child Reached Termination Age or Married <input type="checkbox"/> Death <input type="checkbox"/> Entered Military <input type="checkbox"/> Other (specify) _____ Names of Dependents Being Deleted: _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)										
C. CONTINUING COVERAGE UNDER COBRA <input type="checkbox"/> Spouse of Deceased Employee <input type="checkbox"/> Divorced <input type="checkbox"/> Reduction in hours/no longer meets Group's eligibility requirements <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Employment Terminated <input type="checkbox"/> Disabled <input type="checkbox"/> 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 Pennsylvania") 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 Pennsylvania 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 Pennsylvania and such services which are rendered on or after the effective date of coverage. I authorize Rayant Insurance Company of Pennsylvania 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 _____	



Rayant Insurance Company of Pennsylvania
A Horizon Company

PENNSYLVANIA
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 Option Plus <input type="checkbox"/> Rayant Dental PPO <input type="checkbox"/> Rayant Dental PPO Access		1B INSURER Rayant Insurance Company of Pennsylvania		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). <input checked="" type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other <input type="checkbox"/> Adding/Deleting Dependents <input type="checkbox"/> Rehire <input type="checkbox"/> Newly Eligible <input type="checkbox"/> COBRA				4 COVERAGE REQUESTED Please check the appropriate box Type of Contract: Single, Husband and Wife, Domestic Partners, Family, Parent and Child(ren) Family: <input checked="" type="checkbox"/>							
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? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no If yes, indicate the number of hours worked per week: _____ If no, check the appropriate box: <input type="checkbox"/> Pensioner <input type="checkbox"/> Disabled <input type="checkbox"/> 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		FIRST NAME		MI	DATE OF BIRTH MO DAY YR	SEX M/F	FULL TIME STUDENT OVER CONTRACT AGE	HANDICAP OVER CONTRACT AGE	SOCIAL SECURITY NUMBER		
Applicant Doe		John		R	01 01 48	M					
Spouse/Domestic Partner Doe		Jane		E	02 02 51	F					
Child Doe		Mary		A	03 03 76	F	<input checked="" type="checkbox"/>				
Child											
Child											
Child											
Legal Ward											
* Verification is required for dependents over contract age for full time students and handicapped.							B. MARITAL STATUS OF APPLICANT <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widower <input type="checkbox"/> Domestic Partner (Please attach proof of Domestic Partnership)				
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, Middle Initial) 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.) <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Ward <input type="checkbox"/> Spouse's Coverage Terminated <input type="checkbox"/> Child <input type="checkbox"/> Adoption <input type="checkbox"/> Previously Refused/Waived Coverage <input type="checkbox"/> Other (specify) _____											
B. DELETING DEPENDENT(S) <input type="checkbox"/> Divorced/Separation <input type="checkbox"/> Coverage Elsewhere <input type="checkbox"/> Child Reached Termination Age or Married <input type="checkbox"/> Death <input type="checkbox"/> Entered Military <input type="checkbox"/> Other (specify) _____ Names of Dependents Being Deleted: _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)											
C. CONTINUING COVERAGE UNDER COBRA <input type="checkbox"/> Spouse of Deceased Employee <input type="checkbox"/> Divorced <input type="checkbox"/> Reduction in hours/no longer meets Group's eligibility requirements <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Employment Terminated <input type="checkbox"/> Disabled <input type="checkbox"/> 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 Pennsylvania") 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 Pennsylvania 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 Pennsylvania and such services which are rendered on or after the effective date of coverage. I authorize Rayant Insurance Company of Pennsylvania 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						FOR PLAN USE ONLY INPUT DATE AND INITIAL VERIFY DATE AND INITIAL					

8646 (W0607)

RAYANT INSURANCE COMPANY OF PENNSYLVANIA - WHITE COPY EMPLOYER - YELLOW COPY