

For Residents of Wisconsin

## Preferred Insurance Affiliates, Inc. Dental Plan

**ELIGIBILITY:** You must be a resident of a long-term care facility at which the Preferred Insurance Affiliates, Inc. offers the Dental Plan.

# ENROLLEE INFORMATION: Name: (please print): Date of Birth: Medicaid Recipient Identification Number: Long-term care facility (please print): Name of Facility Address City State Zip

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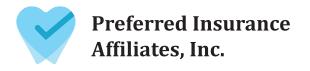
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# **SELECTYOUR POLICY**

# PLEASE CHECK ONLY ONE OF THE CHOICES BELOW:

The premium is [\$825.84] per year ([\$68.82 per month) for the first Benefit Year and payable in advance in semi-annual installments of [\$412.92] each	d is	
☐ \$1,500 Annual Maximum Benefit		
The premium is [\$1,138.52] per year ([\$94.88] per month) for the first Benefit Year payable in advance in semi-annual installments of [\$569.26] each	and is	
☐ \$2,500 Annual Maximum Benefit		
The premium is [\$1,375.74] per year ([\$114.65] per month) for the first Benefit Year payable in advance in semi-annual installments of [\$687.87] each	r and is	
The premium may change at the beginning of a Benefit Year. The Plan will provide notice of any change in premium not less than 30 days prior to the first day of the Benefit Year for which such change is effective. In the event that any change in premium is greater than 25%, the Plan will provide notice not less than 60 days prior to the first day of the Benefit Year for which such change is effective.		
PLEASE CHECK ONLY ONE OF THE CHOICES BELOW:		
YES, I elect coverage under the Preferred Insurance Affiliates, Inc. Dental Plan progr I hereby confirm that I am eligible for Wisconsin Medicaid and that I am currently a residue.		
of a long term care facility. I understand that a licensed dentist approved by the facility a selected by Preferred Insurance Affiliates, Inc. Dental Plan will provide the dental care be Furthermore, I understand that I will not incur any out-of-pocket cost for services in the Preferred Insurance Affiliates, Inc. Dental Plan Schedule of Benefits subject to annual main Section 9, the limitations in Section 10 and exclusions in Section 11.1 agree to have must fund sources available for healthcare benefits adjusted to cover the Preferred Insurance Inc. Dental Plan premium. I hereby authorize the long-term care facility at which I am a to disburse the premiums to Preferred Insurance Affiliates, Inc. Dental Plan on a timely be	enefits. e ximum ny public Affiliates, resident	

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### RENEWABILITY, CANCELLATION AND TERMINATION OF POLICY:

Coverage under the Preferred Insurance Affiliates, Inc. Dental Plan will be for a 12-month Benefit Year and will be effective (the "Coverage Effective Date") on the first day of a calendar month, as follows. Upon receipt of paid premium, the Coverage Effective Date and the start of the Benefit Year for coverage will begin on the 1st day of the immediately succeeding month.

Premiums are payable in semi-annual installments on the first day of a Benefit Year and on the first day of the seventh month of a Benefit Year. Coverage will renew automatically on an annual basis, subject however to termination or disenrollment as follows:

- A. You or the Preferred Insurance Affiliates, Inc. Dental Plan may terminate coverage as of the last day of a Benefit Year upon not less than 60 days prior written notice of termination to the other;
- B. There is a 31-day grace period for premium payments. You must pay your premium before the end of the grace period. At that point, PI will terminate your coverage if premium is still unpaid. If non-payment of premium terminates your coverage, a subsequent acceptance of premium by PI or by any agent duly authorized by the insurer to accept such premium will reinstate coverage. Coverage becomes effective again as of the date of payment acceptance.
- C. You or Preferred Insurance Affiliates, Inc. may terminate coverage at any time upon not less than 60 days prior notice to the other party. No refund of premium will occur if termination of coverage pursuant to this Section 3(c) occurs prior to the last day of the sixth month of the first Benefit Year. If termination of coverage pursuant to this Section 3(c) occurs after the last day of the sixth month of the first Benefit Year, Preferred Insurance Affiliates, Inc. will refund you the unearned prorated premium based upon the "Premium Refund Table" filed with the Department of Insurance, less a 10% short rate penalty.

Preferred Insurance Affiliates, Inc. advised me in good faith that this policy is suitable for my situation and me.

I agree that Preferred Insurance Affiliates, Inc. Dental Plan has the exclusive right to select the Dentist to provide the dental services in the Schedule of Benefits.

Preferred Insurance Affiliates, Inc. will issue me a copy of the Policy and the included Dental Plan Schedule of Benefits within 30 days after receipt of my paid premium.

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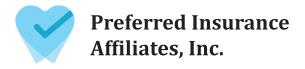
I hereby declare that the statements and answers provided on this Policyholder Application are true, accurate and complete on the date hereof.

Resident signature:
Dated:
And/or Responsible party's signature:
Relationship:
Dated:
Witness (if necessary):
Second witness:
***************************************
Agent signature:
Agent License #:
Dated:
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### **Attachments:**

I. Release of Medical and Dental Records

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### **RELEASE OF MEDICAL AND DENTAL RECORDS**

I agree to the release of all of my medical and dental records to Preferred Insurance Affiliates, Inc. and/or its contracted dental provider.

These records will include treatment histories, diagnoses and any chronic health conditions, surgeries and prescription medications taken.

Preferred Insurance Affiliates, Inc. will use this information solely to aid in understanding my health history as it pertains to future dental care.

Additionally, my authorized representative may agree to this release if I am unable.

Resident signature:	
Dated:	
And/or Responsible party's signature:	
Relationship:	
Dated:	

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# **AUTO PAY FROM CHECKING OR SAVINGS ACCOUNT**

If you wish to have the monthly premium automatically deducted from your Checking or Savings Account, complete the following authorization and sign and date below.

If you do not wish to set up the automatic premium deduction option, you do not need to complete this form.

I hereby authorize Preferred Insurance Affiliates, In	
bank named below, to initiate monthly debit entrie	s for my dental premium:
Name of Account Holder:	Account Type:   Checking
	$\square$ Savings
Bank Name:	
City: State: Zip:	_
Transit/ABA No:	_Account No:
Attach a Voided Check for Checking/Savings Accoun	nt Auto-Payment
By signing, I authorize the debiting of my checking This includes any premium increases or reinstatem authorization is to remain in full force and effect up the authorization and that notification has been repreferred Insurance Affiliates or its authorized admit. I understand that Preferred Insurance Affiliates, I to terminate this payment convenience option at a	nent fees provided in the policy. This ntil I provide written notification to terminate ceived in such time and manner as to afford ninistrator a reasonable opportunity to act on inc. or its authorized administrator may elect
Signature of Account Holder	

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