Preferred Insurance Affiliates, Inc.

POLICYHOLDER APPLICATION
FOR MEDICAID ELIGIBLE RESIDENTS

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

SELECT YOUR POLICY

PLEASE CHECK ONLY ONE OF THE CHOICES BELOW:

☐ $750 Annual Maximum Benefit

The premium is [$825.84] per year ([$68.82 per month) for the first Benefit Year and is payable in advance in semi-annual installments of [$412.92] each

☐ $1,500 Annual Maximum Benefit

The premium is [$1,138.52] per year ([$94.88] per month) for the first Benefit Year and is payable in advance in semi-annual installments of [$569.26] each

☐ $2,500 Annual Maximum Benefit

The premium is [$1,375.74] per year ([$114.65] per month) for the first Benefit Year and is payable in advance in semi-annual installments of [$687.87] each

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 program. I hereby confirm that I am eligible for Wisconsin Medicaid and that I am currently a resident of a long term care facility. I understand that a licensed dentist approved by the facility and selected by Preferred Insurance Affiliates, Inc. Dental Plan will provide the dental care benefits. 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 maximum in Section 9, the limitations in Section 10 and exclusions in Section 11. I agree to have my public fund sources available for healthcare benefits adjusted to cover the Preferred Insurance Affiliates, Inc. Dental Plan premium. I hereby authorize the long-term care facility at which I am a resident to disburse the premiums to Preferred Insurance Affiliates, Inc. Dental Plan on a timely basis.

___ NO, I do not want coverage under the Preferred Insurance Affiliates, Inc. Dental Plan Program. However, I do want to receive dental care, upon request, from a Preferred Insurance Affiliates, Inc. Dental Plan dentist. Care will be according to the stated Medicaid limited benefits. I understand that I may be responsible to pay the charges for individual services provided by the dentist.

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 pro-rated 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.

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: _____

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Agent signature: _____

Agent License #: _____

Dated: _____

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Attachments:

1. Release of Medical and Dental Records

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: _____

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, Inc. or its authorized administrator and the bank named below, to initiate monthly debit entries for my dental premium:

Name of Account Holder:_____ Account Type: ☐ Checking
☐ Savings

Bank Name:_____

City:_____ State:_____ Zip:_____

Transit/ABA No:_____ Account No:_____

Attach a Voided Check for Checking/Savings Account Auto-Payment

By signing, I authorize the debiting of my checking or savings account for my dental premium. This includes any premium increases or reinstatement fees provided in the policy. This authorization is to remain in full force and effect until I provide written notification to terminate the authorization and that notification has been received in such time and manner as to afford Preferred Insurance Affiliates or its authorized administrator a reasonable opportunity to act on it. I understand that Preferred Insurance Affiliates, Inc. or its authorized administrator may elect to terminate this payment convenience option at any time.

_____ _____

Signature of Account Holder Date