VERIFICATION OF ELIGIBILITY FORM

EMPLOYER

NEW BUSINESS SUBMISSION

Please complete this form of eligibility and provide with new case submission documents. Statements made herein may be used to contest a claim of the validity of any policy issued. If a policy is issued, please see such policy for more information.

1) Employer's name_____
2) Employer's Phone Number_____
3) Total number of employees on payroll_____
4) Total number of employees working part-time (as defined by employer in the employer application) and includes temporary and/or seasonal employees_____
5) Total number of employees in waiting period_____
6) Number of full-time eligible employees (subtract numbers 4 & 5 from number 3)_____
7) Total number of employees who are covered under their spouse's plan (an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file)_____
8) Number of eligible employees (subtract 7 from 6)_____
9) Number of full-time employees enrolled_____
10) Premium information:
    ___ 100% Employer Paid, or
    ___ Employer pays _____% of employee premium, and
    ___ Employer pays _____% of dependent premium

AGREEMENT AND SIGNATURES

It is understood and agreed as follows:

1) No coverage is effective until approved by Argus Dental & Vision, Inc.
2) Coverage will be effective with regard to those individuals listed in the Eligibility section of the application on the latest of the following dates: a) effective date approved by the company, b) the date the application is signed, or c) the date the first premium is paid in full.
3) No agent has the authority to waive any of the company's right or requirements, or to make or alter any contract or policy.
4) The employer applicant agrees to notify Argus Dental & Vision, Inc. of any changes to the above numbers representing a change of ten percent (10%) or more and the employer further agrees to provide Argus Dental & Vision, Inc. with payroll records verifying number of employees upon request.
5) The employer applicant agrees and understands that if the contributory status or participation percentages change, that Argus Dental & Vision, Inc. reserves the right to adjust the premiums and rates accordingly.

Dated at_____this____day of _____, 20_____.

_____ _____
Signature of Writing Agent Agent ID — Employer Applicant Signature

_____ _____
Type or Print Agent's Name(s) — Type or Print Name

_____ _____
Agent's Business Address (City/State/Zip) — Title

_____ _____
Agency Agency Code — Company Name