



**Rate  
Information**

# Dental Cents<sup>®</sup>

**A COMMON SENSE  
DENTAL PLAN  
FOR GROUPS OF  
2 THROUGH 9  
EMPLOYEES**

# Standard Industry Code (SIC) Factors

FACTOR IS 1.00 IF SIC CODE IS NOT SHOWN BELOW

## Industry Discount

	<b>SIC Code</b>	<b>Discount</b>	<b>SIC Factor</b>
Agriculture	0100-0999	-15%	.85
Mining	1000-1499	-15%	.85
Construction	1500-1999	-15%	.85
Manufacturing	2000-3999	-10%	.90
Transportation	4000-4299	-10%	.90
	4400-4499	-10%	.90
Pipeline	4600-4699	-10%	.90
Transport Services	4700-4799	-10%	.90
Utilities	4900-4999	-10%	.90

## Industry Surcharge

	<b>SIC Code</b>	<b>Surcharge</b>	<b>SIC Factor</b>
Banking, Investments	6000-6299	+10%	1.10
Insurance	6300-6499	+10%	1.10
Real Estate	6500-6699	+10%	1.10
Holding Companies	6700-6999	+10%	1.10
Amusement Companies	7800-7999	+10%	1.10
Health Services	8000-8049	+15%	1.15
	8070-8099	+15%	1.15
Legal Services	8100-8199	+15%	1.15
Miscellaneous Services/Organizations	8300-8999	+15%	1.15
Public Administration	9000-9999	+15%	1.15
Education	8200-8299	+25%	1.25

Dentists and Dental Labs (SIC 8021, 8072) Ineligible For Dental Coverage

Companion Life reserves the right to decline to propose benefits for any business or industry which does not, in our opinion, represent a sound underwriting risk.

# Base Rates

Rates Are Guaranteed For 12 Months.

Effective January 1, 2010

PLAN A Monthly Base Rate													
Dental Cents - Plan A - Jan 2010 - Mar 2010													
\$100 Lifetime Deductible, 100/80/50, 12 month waiting period on Class III Procedures, \$1,000 Max													
	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L	Area M
Employee	\$25.31	\$26.64	\$27.98	\$29.61	\$31.26	\$32.90	\$34.55	\$36.51	\$38.50	\$40.80	\$42.78	\$45.41	\$47.70
Employee + 1	\$48.11	\$50.62	\$53.17	\$56.28	\$59.38	\$62.50	\$65.66	\$69.39	\$73.14	\$77.52	\$81.28	\$86.29	\$90.62
Employee + 2+	\$75.69	\$79.65	\$83.66	\$88.56	\$93.45	\$98.34	\$103.32	\$109.18	\$115.10	\$121.99	\$127.90	\$135.78	\$142.60
PLAN B Monthly Base Rate													
Dental Cents - Plan B - Jan 2010 - Mar 2010													
\$25 Preventive and \$50 Basic & Major Contract Year Deductibles, 100/80/50, 12 month waiting period on Class III Procedures, \$1,000 Max													
	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L	Area M
Employee	\$24.82	\$26.11	\$27.43	\$29.03	\$30.63	\$32.23	\$33.87	\$35.78	\$37.73	\$39.98	\$41.92	\$44.50	\$46.75
Employee + 1	\$47.15	\$49.61	\$52.11	\$55.15	\$58.20	\$61.24	\$64.35	\$67.99	\$71.67	\$75.96	\$79.66	\$84.56	\$88.81
Employee + 2+	\$74.18	\$78.06	\$81.99	\$86.78	\$91.58	\$96.37	\$101.25	\$107.00	\$112.80	\$119.54	\$125.34	\$133.06	\$139.75
PLAN C Monthly Base Rate													
Dental Cents - Plan C - Jan 2010 - Mar 2010													
\$15 Copay per Visit, 100/0/0, \$1,000 Max													
	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L	Area M
Employee	\$11.22	\$11.81	\$12.40	\$13.12	\$13.85	\$14.57	\$15.31	\$16.18	\$17.06	\$18.07	\$18.96	\$20.12	\$21.14
Employee + 1	\$21.31	\$22.43	\$23.56	\$24.94	\$26.31	\$27.69	\$29.09	\$30.74	\$32.41	\$34.34	\$36.01	\$38.22	\$40.15
Employee + 2+	\$40.18	\$42.28	\$44.40	\$47.00	\$49.59	\$52.19	\$54.83	\$57.95	\$61.09	\$64.74	\$67.88	\$72.07	\$75.69
PLAN D Monthly Base Rate													
Dental Cents - Plan D - Jan 2010 - Mar 2010													
\$50 Contract Year Deductible, 100/80/50, 12 month waiting period on Class III Procedures, \$1,000 Max													
	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L	Area M
Employee	\$28.30	\$29.77	\$31.27	\$33.10	\$34.93	\$36.75	\$38.62	\$40.81	\$43.02	\$45.60	\$47.81	\$50.75	\$53.30
Employee + 1	\$53.76	\$56.56	\$59.42	\$62.89	\$66.37	\$69.84	\$73.38	\$77.53	\$81.73	\$86.63	\$90.83	\$96.42	\$101.28
Employee + 2+	\$84.59	\$89.01	\$93.49	\$98.96	\$104.43	\$109.89	\$115.47	\$122.01	\$128.62	\$136.31	\$142.93	\$151.73	\$159.36

See Dental "Cents" brochure (95067) for information on policy benefits and limitations.

**Orthodontia (optional – available only with Plans A, B and D) – Monthly Base Rate \$4.65 (All Areas)**

**Add to all dependent rates – Employee plus 1, Employee plus 2 plus**

## Quarterly Adjustment Factor

**April 2010 - June 2010 1.02    July 2010 - September 2010 1.03    October 2010 - December 2010 1.04**  
**Applied to Base Rates Above**

## Rate Formula

Using Rates For    PLAN A     PLAN B     PLAN C     PLAN D

Proposed Effective Date \_\_\_\_\_ Area \_\_\_\_\_

	Monthly Rate	Quarterly Adjustment Factor	SIC Factor	Orthodontia Rate (Optional for Plans A, B and D)	Number Enrolling	Cost
Employee Only	\$ _____	x _____	x _____	N/A	x _____	= \$ _____
Employee +1	\$ _____	x _____	x _____	+	x _____	= \$ _____
Employee +2+	\$ _____	x _____	x _____	+	x _____	= \$ _____
					Monthly Administration Fee	+ \$ 15.00
					<b>Total Cost</b>	<b>\$ _____</b>



P.O. Box 100102, Columbia, SC 29202

DENTAL EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

EMPLOYER (APPLICANT) INFORMATION (Please Print or Type)

Legal Name of Employer \_\_\_\_\_

Type of Business (Sole Proprietorship, Partnership, Corporation, etc.) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Contact \_\_\_\_\_ Title \_\_\_\_\_ (Person to contact concerning coverages)

No. of Eligible Employees : \_\_\_\_\_ No. of Eligible Employees Enrolled: \_\_\_\_\_

Effective Date Requested: \_\_\_\_\_ SIC Code and Nature of Business: \_\_\_\_\_

(The firm's effective date will be the first or the 15th of the month following written acceptance by Companion Life Insurance Company.)

How many years in this business? \_\_\_\_\_ How many years at this location? \_\_\_\_\_

Tax I.D. Number: \_\_\_\_\_ No. of Family Members in Organization: \_\_\_\_\_

PLAN DESCRIPTION

PLAN REQUESTED:

- Plan A: I - 100% II - 80% III - 50% - \$1,000 Annual Maximum - \$100 Lifetime Deductible
Plan B: I - 100% II - 80% III - 50% - \$1,000 Annual Maximum - \$25/\$50 deductible
Plan C: I - 100% II - N/A III - N/A - \$1,000 Annual Maximum - \$15 copay per visit
Plan D: I - 100% II - 80% III - 50% - \$1,000 Annual Maximum - \$50 Contract Year Deductible

Are Orthodontia Benefits requested? (Plans A, B and D only) [ ] Yes [ ] No

Are Takeover Benefits requested? [ ] Yes [ ] No If yes, please provide the following:

a. Name of Prior Carrier: \_\_\_\_\_

b. Effective Date of Prior Plan: \_\_\_\_\_ c. Termination Date of Prior Plan: \_\_\_\_\_

Also, submit a copy of your previous insurance carrier's most recent billing statement as well as a certificate or letter of acceptance that shows the effective date of your policy along with a copy of your previous carrier's certificate, booklet or schedule of benefits. If prior carrier's bill does not include the effective date of each employee's coverage, please note this information next to each employee's name so we can give the correct credit for transfer of benefits.

Employment Waiting Period: [ ] 1 Month [ ] Other: \_\_\_\_\_ (No waiting period applies to those employed on the effective date.)

Coverage following the completion of the waiting period selected will be effective on the first or the 15th of the month only.

The employer agrees to contribute the following percentage of the cost of employee dental insurance for all covered employees \_\_\_\_\_% (25% required)

FRAUD WARNING: (Not Applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING: (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Participation Agreement (Administered and underwritten by Companion Life Insurance Company)

The Participant hereby applies for Group Insurance Benefits as set forth in the above "Dental Employer Participation Application for the Joint Employer Group Insurance Trust" and subscribes to the Agreement and Declaration of Trust.

Name of Trust: The Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does the Trustee have any obligation under any policy of insurance and that all claims for and benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy(ies). The Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666.

(Signature of Employer/Applicant)

(Title) (Date)

This is to certify that I, the undersigned agent, have truly and accurately recorded on this application form the information supplied.

(Signature of Agent/Broker) (Date)

Print Agent/Broker's Name License No.

FOR HOME OFFICE USE

Accepted by Administrator Effective: \_\_\_\_\_

By: \_\_\_\_\_

(Title) (Date)

# Area Table

(By First 3 Digits of ZIP Code)

<b>Alabama</b>	C	<b>Kansas</b>		<b>Mississippi</b>		<b>Pennsylvania</b>	
<b>Arkansas</b>	C	661-662	D	392	D	190-192	I
<b>Delaware</b>		660, 672	C	All Others	C	189, 193-194	H
197, 198	I	664-668	B	<b>Missouri</b>		180-181	F
All Others	D	All Others	A	640-641, 649	E	150-152, 176, 179	E
<b>District of Columbia</b>	M	<b>Kentucky</b>		631	D	182-183, 186-188	E
<b>Florida</b>		402, 405-406, 410	D	630, 633	C	195-196	E
330-332, 340	L	All Others	C	658	B	153-157, 159	D
333-335, 337	J	<b>Louisiana</b>		All Others	A	164-166, 168	D
341	I	701	G	<b>Montana</b>		170-175, 184-185	D
329, 336, 339	H	700, 704, 707-708	E	591, 598	E	All Others	C
342, 346, 349	H	All Others	D	All Others	D	<b>Rhode Island</b>	H
320, 322, 326-328	G	<b>Maine</b>		<b>Nebraska</b>	A	<b>South Dakota</b>	C
338, 344, 347	G	040-041	H	<b>Nevada</b>	F	<b>Tennessee</b>	
All Others	F	042, 044-046, 048	G	All Others		372	D
<b>Georgia</b>		All Others	F	<b>New Hampshire</b>		All Others	C
303, 311, 399	G	<b>Maryland</b>		030-031, 033	I	<b>Texas</b>	
300	F	208-209	L	All Others	H	752-753, 770-772	G
301, 302	E	207	K	<b>North Carolina</b>		750-751	F
305-306, 308-309	C	206	I	276, 282	F	733, 760-761, 786-787	E
307, 310, 312-314	B	212	H	271, 277	E	762-763, 773-775	D
316-319, 398	B	210-211, 214, 219	G	270, 272-275	D	790-792	C
All Others	A	215, 217	F	280-281, 286-289	D	All Others	B
<b>Idaho</b>		All Others	E	All Others	C	<b>Vermont</b>	G
833, 835-838	D	<b>Massachusetts</b>		<b>North Dakota</b>	C	<b>Virginia</b>	
All Others	C	021-022	K	<b>Ohio</b>		201, 220-223	J
<b>Illinois</b>		016-018, 024-026, 055	J	441-443, 452	F	224-225, 233-237	G
600, 602, 606-608	J	013-015, 019-020	I	430-432, 436, 440	E	226-232, 238, 244	F
601, 603	I	023, 027	I	434-435, 444-445, 447	D	240-241	D
604-605	H	010-011	H	450-451, 454, 456	D	All Others	C
610-611, 627	E	All Others	G	All Others	C	<b>Washington</b>	
609, 613-618, 623	D	<b>Michigan</b>		<b>Oklahoma</b>		980-981	L
All Others	C	480	J	730-731, 740-741	E	985-986, 990-992	K
<b>Indiana</b>		481-483	I	All Others	D	All Others	J
462	F	484-485	G	<b>Oregon</b>		<b>West Virginia</b>	C
463-466	E	488-489	F	972	J	<b>Wisconsin</b>	
460-461, 467-469	D	486-487, 490-492	E	970-971	I	532, 534, 537, 543	G
473, 479	D	All Others	D	974-979	H	549	F
All Others	C	<b>Minnesota</b>		All Others	G	530-531, 539, 547	E
<b>Iowa</b>		550, 551, 553-555	G	<b>Wyoming</b>		All Others	D
500-503, 509	D	556-564	F				
All Others	C	All Others	D				

# How To Enroll

- 1 Arrive at final rates for the group by:
  - A. Determining the group's **rate area**, **quarterly adjustment factor** and **SIC factor** using charts included;
  - B. Then, determining the monthly **base rates** for the group's desired plan on the enclosed Rate Sheet and completing the Rate Formula at the bottom of the Rate Sheet.
- 2 Complete the Employer Participation Application. If Takeover from a previous dental carrier, please submit:
  - A. A copy of their previous insurance carrier's most recent billing statement;
  - B. A certificate or letter of acceptance from their previous insurance carrier that shows the effective date of their policy; and
  - C. A copy of their previous insurance carrier's certificate, booklet or schedule of benefits.
- 3 Have an Employee Enrollment Card completed by each full-time employee.
- 4 Have the group's check for one month's premium payable to: **Companion Life Insurance Company**.
- 5 Mail Rate Calculation, Employer Participation Application, Employee Enrollment Cards and the check to:

**Group Marketing  
Companion Life Insurance Company  
P.O. Box 100102  
Columbia, SC 29202-3102**

If you have any questions, please call **1-800-753-0404** and ask for **Group Marketing**.



P.O. Box 100102  
Columbia, SC 29202-3102

(800) 753-0404    FAX (800) 836-5433

E-mail: [c.life@companiongroup.com](mailto:c.life@companiongroup.com)

[www.CompanionLife.com](http://www.CompanionLife.com)