rayant[SM]

Rayant Insurance Company of New York
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 Options
- Check off Dental Plan

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℠

Rayant Insurance Company of New York
A Horizon Company

NEW YORK 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)

- ☐ Rayant Dental Option
- ☐ Rayant Dental EPO
- ☐ Rayant Dental PPO
- ☐ Rayant Dental PPO Access

1B INSURER

Rayant Insurance Company of New York

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).

- ☐ New Hire
- ☐ Rehire
- ☐ Adding/Deleting Dependents
- ☐ Newly Eligible
- ☐ Open Enrollment
- ☐ COBRA
- ☐ Other _____

4 COVERAGE REQUESTED

Please check the appropriate box

Type of Contract	Single	Husband and Wife	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? ☐ yes ☐ no

If yes, indicate the number of hours worked per week _____

If no, check the appropriate box: ☐ Pensioner ☐ Disabled ☐ 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	LAST 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 ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

7 APPLICANT'S ADDRESS AND PHONE NUMBER

Street

City State Zip Code

Area 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.)

☐ Marriage ☐ Legal Ward ☐ Spouse's Coverage Terminated ☐ Child ☐ Adoption ☐ Previously Refused/Waived Coverage ☐ Other (specify) _____

B. DELETING DEPENDENT(S)

☐ Divorced/Separation ☐ Coverage Elsewhere ☐ Child Reached Termination Age or Married
☐ Death ☐ Entered Military ☐ Other (specify) _____

Names of Dependents Being Deleted: _____

☐ Spouse ☐ Child(ren)

C. CONTINUING COVERAGE UNDER COBRA

☐ Spouse of Deceased Employee ☐ Divorced ☐ Reduction in hours/no longer meets Group's eligibility requirements ☐ Other (specify) _____
☐ Employment Terminated ☐ Disabled ☐ 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 New York") 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 New York 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 New York and such services which are rendered on or after the affective date of coverage. I authorize Rayant Insurance Company of New York 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℠

Rayant Insurance Company of New York
A Horizon Company

NEW YORK 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)

- ☐ Rayant Dental Option
- ☐ Rayant Dental EPO
- ☐ Rayant Dental PPO
- ☐ Rayant Dental PPO Access

1B INSURER

Rayant Insurance Company of New York

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).

- ☒ New Hire
- ☐ Rehire
- ☐ Adding/Deleting Dependents
- ☐ Newly Eligible
- ☐ Open Enrollment
- ☐ COBRA
- ☐ Other _____

4 COVERAGE REQUESTED

Please check the appropriate box

Type of Contract	Single	Husband and Wife	Family	Parent and Child(ren)
			X	

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? ☒ yes ☐ no

If yes, indicate the number of hours worked per week _____

If no, check the appropriate box: ☐ Pensioner ☐ Disabled ☐ 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	LAST 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**	X*	*	
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 ☐ Single ☒ Married ☐ Divorced ☐ Widow(er)

7 APPLICANT'S ADDRESS AND PHONE NUMBER

Street: **5 Deer Trail Rd**

City: **Wildwood** State: **NJ** Zip Code: **08260**

Area Code: **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): **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.)

☐ Marriage ☐ Legal Ward ☐ Spouse's Coverage Terminated ☐ Child ☐ Adoption ☐ Previously Refused/Waived Coverage ☐ Other (specify) _____

B. DELETING DEPENDENT(S)

☐ Divorced/Separation ☐ Coverage Elsewhere ☐ Child Reached Termination Age or Married
☐ Death ☐ Entered Military ☐ Other (specify) _____

Names of Dependents Being Deleted: _____

☐ Spouse ☐ Child(ren)

C. CONTINUING COVERAGE UNDER COBRA

☐ Spouse of Deceased Employee ☐ Divorced ☐ Reduction in hours/no longer meets Group's eligibility requirements ☐ Other (specify) _____
☐ Employment Terminated ☐ Disabled ☐ 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 New York") 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 New York 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 New York and such services which are rendered on or after the affective date of coverage. I authorize Rayant Insurance Company of New York 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**

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