

Patriot Health Insurance Company, Inc.
Employer Application & Agreement for Group Insurance



(Each section must be completed below)

Section 1 -- FOR INTERNAL USE			
Group No.	Active Div. No.	Plan No.	COBRA Div. No.

Section 2 -- TO BE COMPLETED BY BROKER OR EMPLOYER

<input type="checkbox"/> New Group <input type="checkbox"/> Rate Change <input type="checkbox"/> Renewing Group <input type="checkbox"/> Benefit Change	<table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: center; border-bottom: 1px solid black;">PLAN</th> <th colspan="3" style="text-align: center; border-bottom: 1px solid black;">DEDUCTIBLE (Calendar Year)</th> </tr> <tr> <td style="border-bottom: 1px solid black;">* <input type="checkbox"/> Signature Plus Plan</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> 1200/2400</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> 2500/5000</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> 5000/10,000</td> </tr> <tr> <td style="border-bottom: 1px solid black;">* <input type="checkbox"/> Signature Plan</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> 1200/2400</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> 2500/5000</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> 5000/10,000</td> </tr> <tr> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> Standard Plan</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> 500/1000</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> 1000/2000</td> <td></td> </tr> </table> <p>* Note: Signature Plans are NOT creditable coverage for purposes of Medicare Part D.</p>	PLAN	DEDUCTIBLE (Calendar Year)			* <input type="checkbox"/> Signature Plus Plan	<input type="checkbox"/> 1200/2400	<input type="checkbox"/> 2500/5000	<input type="checkbox"/> 5000/10,000	* <input type="checkbox"/> Signature Plan	<input type="checkbox"/> 1200/2400	<input type="checkbox"/> 2500/5000	<input type="checkbox"/> 5000/10,000	<input type="checkbox"/> Standard Plan	<input type="checkbox"/> 500/1000	<input type="checkbox"/> 1000/2000	
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For groups with effective dates of 10/1 or 11/1:
(Only available for Signature Plans)
 4th quarter carry-over option?
 YES NO

Employer Name	Effective Date / /	Renewal Month
Street Address (Mailing Address)	City	State Zip Code
Phone Number	Fax Number	Tax ID Number Date Business Established / /
Employer Contact (Name & Title)	Contact Phone No. () -	Contact e-mail address:
SIC	Nature of Business	

Is your company a: sole proprietor partnership or LLC corporation
 Are you a Subsidiary of a Larger Company? Yes No
 If you are a Subsidiary, Which Company? _____
 Does your company have additional Subsidiaries not included for the purposes of this Application? Yes No
 If you have additional Subsidiaries, please list: _____
 New Hire Policy (probationary period): 1 Month 2 Months 3 Months Other (describe below): _____

Rehire Policy:	Do you plan to offer coverage to domestic partners? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please select applicable eligibility type <input type="checkbox"/> Same Sex <input type="checkbox"/> Opposite Sex
Patriot Healthcare Termination Policy: 1st day of the month after date of termination		

Billing Level Group Division Plan

Proposal Offering Scenario: Total Replacement
 Offered with another Carrier Name of Other Carrier: _____
 Other Products Offered along side Patriot Healthcare: _____

Please indicate the number of employees in your group in each of the following classifications as of today's date:

(1) Employees on Payroll	(2) Eligible Employees	(3) Employees Enrolling in Plan	(4) Employees Covered through Spouse	(5) Total Employees Covered (3) + (4)	(6) Declined Coverage	(7) % of Participation (5)÷(2)

Monthly Premium Rates for the period beginning _____		through _____			
	Employee Only	Employee & Spouse	Employee & Child(ren)	Family	
<input type="checkbox"/> Signature I**	\$	\$	\$	\$	
<input type="checkbox"/> Signature II**					
<input type="checkbox"/> Signature III**					
<input type="checkbox"/> Standard I	\$	\$	\$	\$	
<input type="checkbox"/> Standard II					

These rates are effective for the period described above.

COBRA administration is provided by Employee Benefit Plan Administration (EBPA) as a service to Patriot customers. If you **do**, **not** want EBPA to provide COBRA administration services, please indicate your decision below. If you are not subject to COBRA, EBPA will administer the 39 week extension.

- I DO want EBPA to provide COBRA administration services
 I DO NOT want EBPA to provide COBRA administration services

Section 3 -- TO BE COMPLETED FOR GROUPS USING BROKER

Agency Name and Address	Agency Phone	Agency Fax
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Broker Name

Section 4 - TERMS AND CONDITIONS

Coverage Provided: Patriot will provide group health coverage to eligible Members under the terms and conditions set out in the Member Certificate.

Premium: Monthly premium is due in advance from the Employer by the first of the effective month. The amount invoiced by Patriot shall reflect Membership as of the first day of the month. The Employer shall pay the invoiced amount even if Membership changes have occurred. Each month, premium will be adjusted reflecting membership changes that occurred in the preceding month.

Premium shall be paid by automatic electronic funds transfer unless another arrangement is agreed to in advance by Patriot. If payment is not received by the last day of the month, claims will be pended. If payment is not received by the 31st day, a termination notice will be mailed. If payment is not received by the 10th day of the following month, the group will be immediately terminated and Patriot will provide written notice of cancellation.

The rates quoted by Patriot shall remain in effect until the Anniversary Date, except that such rates may be increased by Patriot with at least 30 days notice to the Employer in the following cases: (i) the Employer and Patriot agree to a benefit change; (ii) there is a change in the law effecting Patriot's cost of providing coverage, including, but not limited to the addition of mandatory benefits or the imposition of a new tax or surcharge effective prior to the Employer's Anniversary Date.

Patriot shall provide Employer with a premium quote at least 60 days prior to the Anniversary date.

Employer's Termination Right: Employer has the right to terminate coverage under this Agreement with 30 days prior written notice to Patriot.

Employer's Participation in Member Education: The Employer agrees to participate in Patriot's member education by permitting employees to attend meetings and/or access Patriot's website from work at reasonable times as agreed in advance by Patriot and the Employer.

I represent that all information contained in this application for group insurance is complete and correct to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

I acknowledge that the broker named above is the company's Broker of Record.

Section 5 - SIGNATURE

Employer Signature _____	Patriot Healthcare _____
Print Name _____	Print Name _____
Title _____	Title _____
Date _____	Date _____

Same health rates apply to Signature **Plus plans



**DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.
PATRIOT HEALTHCARE SIGNATURE PLUS PLAN
DENTAL CONTRACT APPLICATION**

Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
800-537-1715
www.nedelta.com

PLEASE TYPE OR PRINT LEGIBLY — IN BLUE OR BLACK INK ONLY

GROUP NAME _____ **GROUP # 19000 -** _____

	Plan I <input type="checkbox"/>	Plan II <input type="checkbox"/>
Diagnostic and Preventive		
Diagnostic Evaluations - once in a 6-month period; X-rays (Complete series or panoramic film) once in a 3-year period; Bitewing x-rays once in a 12-month period; X-rays of individual teeth as necessary Preventive Cleanings four times in a 12-month period; Fluoride twice in a 12-month period to age 19; Space maintainers to age 16; Sealants for children to age 19 on permanent molars once in a 3-year period	Covered at 100%	Covered at 100%
Deductible for Basic, Major, and Orthodontics	\$250 per person/ \$750 per family per calendar year	\$500 per person/ \$1,500 per family per calendar year
Basic		
Restorative Amalgam (silver) fillings; Composite (white) fillings Oral Surgery Surgical and routine extractions Endodontics Root canal therapy Periodontics Periodontal maintenance (cleaning): Cleanings four times in a 12-month period; this can be routine or periodontal, but not both Treatment of gum disease Denture Repair Repair of a removable denture to its original condition; Emergency palliative treatment	Covered at 100% after deductible	Covered at 100% after deductible
Major		
Prosthodontics Removable and fixed partial dentures (bridge); Complete dentures; Rebase and reline (dentures); Crowns; Onlays; Implants	Covered at 100% after deductible	Covered at 100% after deductible
Orthodontics		
Orthodontics Correction of crooked teeth for adults and children	Covered at 100% after deductible	Covered at 100% after deductible
	Employee Only Employee & Spouse Employee & Children Family	\$31.90 \$61.86 \$75.19 \$112.80
		\$19.08 \$36.22 \$49.50 \$71.99
Benefit Maximum	\$2,500 per person per calendar year	\$2,500 per person per calendar year

Benefit percentages shown are based upon the actual charge submitted to a maximum of the Participating Dentist's approved fees, or Delta Dental's allowance for Nonparticipating Dentists.

Name of Business: _____

By: **X** _____
(Duly Authorized Signature)

By: _____

Name (please print): _____

Title: _____

Date: _____

Name: **Thomas Raffio**

Title: **President & CEO**

Date: _____