

Group Vision Employer Participation Agreement

Marketed and Administered by:
Dominion Dental Services USA, Inc.
Alexandria, VA 22314

Underwritten by:
Security Life Insurance Company of America
Minnetonka, MN 55343-9137

How to enroll...

- 1) Complete all sections of the Employer Participation Agreement based upon the plan selected. Be sure to sign/date where applicable.
- 2) Submit Employer Participation Agreement to:

Dominion Dental Services USA, Inc.
Attn: Group Service Center
115 South Union Street, Suite 300
Alexandria, VA 22314

If accepted, the undersigned Employer agrees: (a) To make such benefits available to all present employees and all employees becoming eligible in the future; and (b) To make payroll deductions as required for the plan as are applicable to the employees. The undersigned Employer further agrees that only those full-time employees who meet the *eligibility requirements (as defined under Eligibility within the brochure) are to be included, and that participation requirements must be met before the benefit plan can be made effective. The Employer agrees that not less than two (2) non-related employees of the employer's eligible employees must be enrolled in the Vision Plan to prevent cancellation of coverage. This plan does not require any contribution from the employer.

The undersigned Employer requests that benefits be made available to all employees subject to the following conditions:

- a) No coverage for any employees shall take effect until this Agreement and the employee's individual Enrollment Cards are accepted by the Company and the initial premium paid; and
- b) Employer agrees to remit regularly, in advance, the required premium payments to the Administrator and acknowledges and agrees that this Plan is established under and is subject to the provision of the Employee Retirement Income Security Act (ERISA), as amended. The undersigned Employer is the Plan Administrator as defined in ERISA, as amended.

EMPLOYER INFORMATION – please print clearly

Group Name: _____ Payee # _____ Send Correspondence to: _____

Address _____ City: _____ State _____ Zip Code: _____

Phone Number: (____) _____ Fax Number: (____) _____ Email _____

Nature of Business _____ [] Corporation [] Partnership [] Sole Proprietorship [] Other

Subsidiaries and Affiliates Included [] Yes [] No

Name and Address of Subsidiaries & Affiliates whose employees are to be covered: _____

BENEFIT SELECTION

[X] Precision Plan
9765413

Desired Effective Date: 12/1/09

PARTICIPATION AND CONTRIBUTIONS

The undersigned Employer agrees to contribute: EMPLOYEE: \$ 0 /or _____%

EMPLOYEE/SPOUSE: \$ 0 /or _____%

EMPLOYEE/CHILD(REN): \$ 0 /or _____%

EMPLOYEE/FAMILY: \$ 0 /or _____%

There are initially _____ full-time employees of which _____ are enrolled in this Plan.

Applications in Delaware, District of Columbia, Maryland, and Virginia: It is agreed that the Policy will become effective at rates to be determined by Us, provided the application is accepted by Us. The applicant declares that to the best of its knowledge and belief that statements and answers are complete and true.

Authorized Signature _____

Date _____

Applications in Pennsylvania: It is agreed that the Policy will become effective at rates to be determined by Us, provided the application is accepted by Us. The applicant declares that to the best of its knowledge and belief that statements and answers are complete and true. The Employer hereby requests participation under group Policy number series GH-1157 issued to the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under the Policy, based upon the above statements and representations. The Employer must select the coverage and pay the required premium. Those eligible will be covered as described in this application.

Authorized Signature _____

Date _____

Fraud Warnings

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

State Specific Fraud Warnings

Maryland Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Virginia - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.