Crescent Dental

Voluntary Incentive Plan

Underwritten by Companion Life Insurance Company

Employees who choose to participate pay 100% of the premium through payroll deduction.

FEATURES INCLUDE:

- Voluntary participation
- Immediate coverage- no benefit waiting periods
- No deductible for Preventive and Orthodontic services
- $50 deductible for Basic and Major services
- $1,000 lifetime Orthodontia maximum
- Single and family coverage
- Benefits improve in the second and third years of participation

This is not a certificate of insurance. It is a brief description only. The Group Policy alone determines all rights and benefits. Companion Life reserves the right to withdraw this offer at any time.

Monthly Rates* for University of Louisiana at Lafayette.

$35.87 Employee only

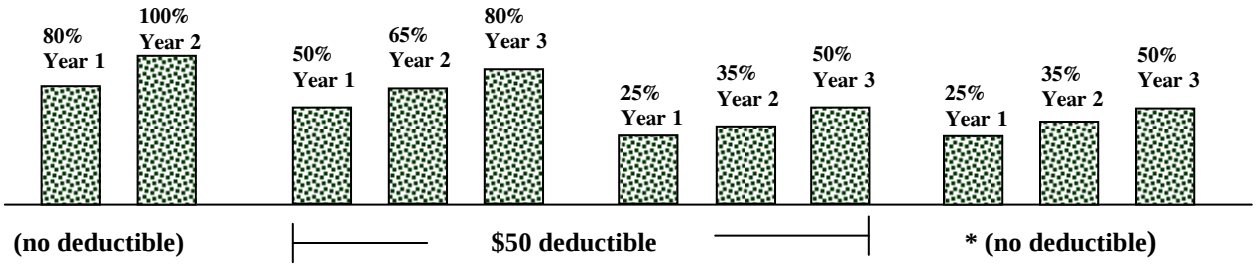
$96.99 Employee plus Family

*Rates based on 12 pay periods per year and are guaranteed until the next policy renewal date.

9/2011

Covered Services

Pays up to $1,000 Annual Benefit for Certain Procedures. Percentage payable is based on Usual & Customary charges for covered procedures



TYPE I
PREVENTIVE SERVICES

Including
Routine Exams (1 per 6 months)
Bitewing X-rays (1 per 6 months.Max of 12 films per 36 months))
Routine Cleaning (1 per 6 months)
Sealants (to age 16)
Fluoride Treatments (to age 19. 1 per 12 months)
Space Maintainers (to age 12)
Emergency Palliative Treatment

TYPE II
BASIC SERVICES

Including
Restorative
Basic Fillings
Oral Surgery (extractions & impacted teeth)
Endodontics (root canal & pulpal therapy)
Periodontics (treatment of gums excluding surgery)
Denture and Crown Repair (1 per quadrant per 12 months)

TYPE III
MAJOR SERVICES

Including
Restorative (inlays & crowns)
Prosthetics (dentures & bridges)
Periodontal Surgery (1 per quadrant per 24 months)

**Deductible is per person per calendar year; (3) per family maximum*

TYPE IV
ORTHODONTIA

Including
Orthodontia (orthodontic care for proper alignment of teeth)
Orthodontia is provided only to dependent children who are under age 19 when treatment is received.
$1,000 Lifetime Maximum

Group Dental Insurance Enrollment Card **Dentemax**

Name of Employer **University of Louisiana at Lafayette**				Group No. and **Dept Name/No.** **D1129**
Employee Name: First Middle Last			☐ Female ☐ Male	Social Security No.
Complete Home Address (Please include street/PO Box, city, state and zip)			Date of Birth	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Date of Hire	Occupation	Effective Date on Dental Plan	If COBRA continues please give: Qualifying Event_____ Date of Event_____	Work at least 30 hrs per week? ☐ Yes ☐ No

Check One: ☐ Employee Only ☐ Employee and Family

List Name, Sex and Date of Birth of each Dependent You Wish to Insure:

Name	Sex	Date of Birth	Name	Sex	Date of Birth
Spouse			3.		
Children			4.		
2.			5.		

Other Dental Carrier: ☐ None

☐ I authorize my employer to deduct from my earnings the amount to cover my share of the contribution for coverage indicated above.

Signature of Employee ***Provisions on reverse side accepted** Date Office Use Only