



Good Neighbor Insurance

**AFTER FILLING OUT THIS APPLICATION
PLEASE MAIL, FAX, OR EMAIL SCAN TO:**

**Good Neighbor Insurance
690 E. Warner Rd. Suite 117
Gilbert, AZ 85296, USA**

Phone: 480-633-9500 / 480-813-9100 • Fax: 480-813-9930

doug@gninsurance.com

www.gnazhealth.com

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**Good Neighbor US Insurance Blog
www.gntravelinsurance.com**



**Tips For Understanding
US Insurance**



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dentalCOMPANIONSM is administered by Total Dental Administrators, Inc. and underwritten by Companion Life Insurance Company. CSA General Insurance Agency, Inc. is the exclusive marketer of dentalCOMPANIONSM.

INDIVIDUAL DENTAL PLAN APPLICATION

Return Completed Application To: Total Dental Administrators • 2111 East Highland Avenue, Suite 250 • Phoenix, Arizona 85016-4741
 Telephone: (602) 266-1995 • Toll Free: (888) 422-1995 • www.TDADental.com

TO BE COMPLETED BY APPLICANT

Applicant's Name: _____ DOB: _____ Sex: _____
Last First MI Month/Day/Year

Applicant's SSN: _____ - _____ - _____ Will dependent children be covered? Yes No

Spouse's Name: _____ DOB: _____ Sex: _____

Spouse's SSN: _____ - _____ - _____

Address: _____ City: _____ ST: _____ ZIP: _____
Street or Post Office Box Apt. Number

Email Address: _____

Home Telephone Number: () _____ - _____ Occupation: _____

COVERAGE INFORMATION

Check Coverage Desired: Individual Individual + 1 dependent Individual + 2 or more dependents

Check Plan Desired: dentalCOMPANION to age 65 dentalCOMPANION age 65+

Please complete dentalCOMPANION Payment Authorization Form # 95378.

TO BE COMPLETED ON EACH DEPENDENT

Name – First, Last, MI	Date of Birth (mm/dd/yyyy)	Sex	SSN	Check if:
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Deletion <input type="checkbox"/> Addition
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Deletion <input type="checkbox"/> Addition
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Deletion <input type="checkbox"/> Addition
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Deletion <input type="checkbox"/> Addition

IMPORTANT INFORMATION AND SIGNATURE PAGE ON THE REVERSE

—OVER—

APPLICANT'S STATEMENTS AND AGREEMENTS

1. I understand the effective date of the policy will be the date recorded in the Policy Schedule of Benefits by Companion Life insurance Company
2. I understand the policy I am applying for contains different Waiting Periods benefits listed in the Policy Schedule of Benefits. This means these benefits **are not payable during the listed Waiting Period**. The Waiting Period begins on the effective date of the policy issued by Companion Life Insurance company.
3. I understand dependent children, if any, may be covered until their 26th birthday regardless of marital or student status.
4. I understand Companion Life Insurance Company is bound by any statement made by me, the applicant, or any associated/agent unless written herein; (b) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy together with this Application, endorsements, benefit agreements, and riders, if any, is the entire contract of insurance; (d) no change to the policy will be valid until approved by the Company's president and secretary, and noted in or attached to the policy; or (e) all statements in this Application are representations and not warranties.

Applicant's Initials: _____

Associate/Agent Initials: _____

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Companion Life Insurance Company may need to obtain additional information about you and any other person(s) proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Companion Life Insurance Company may, in some circumstances, be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of Companion Life Insurance Company information practices, please submit a written request to Companion Life Insurance Company.

Applicant's Initials: _____

Associate/Agent Initials: _____

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (defined below) to Companion Life Insurance Company and/or TDA, Inc., or any person or group acting on their part: any medical professional, any medical care institution, insurer, reinsurer, government agency, consumer reporting agency, or employer. "Information" means facts of a medical nature in regard to my physical condition, employment, or other insurance coverage. I understand this information will be used by Companion Life Insurance Company to determine eligibility for insurance and may be used to evaluate a claim for benefits during the time it is valid. For the purpose of determining eligibility, I agree this authorization is valid for 30 months from the date signed and, for the purpose of evaluating a claim, for the term of the policy. I know I or my authorized representative has a right to receive a copy of this authorization upon request. I agree a copy of this authorization is as valid as the original.

Applicant's Initials: _____

Associate/Agent Initials: _____

ACKNOWLEDGEMENT

If I am applying to replace existing coverage with this policy, I acknowledge the policies may have different benefits and I should make a comparison to personally determine which is best for me. I understand and agree I am terminating my current policy and its benefit for the benefits provided in the Total Dental Administrators Plan, Inc. or Companion Life Insurance Company Policy. I have read, or had read to me, the completed Application, and I realize policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature _____ Date _____

Agent Number 82351 Agent Name Douglas Gullenson

Associate/Agent Signature _____ Date _____
Licensed Resident Associate/Agent

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NOTE: Application is two (2) pages and shall only be accepted if both pages of the Application are returned together. The Application must be complete, initialed, and signed by the Applicant and the Associate/Agent.



Application to:
 Total Dental Administrators • 2111 E. Highland Ave. Suite 250 • Phoenix, AZ 85016
 602-266-1948 FAX • www.TDA Dental.com

**dentalCOMPANION
 PAYMENT AUTHORIZATION**

Applicant's Name _____ First Name _____ M.I. _____
 Birth Date (M/D/Y) _____ Social Security # _____ Gender Male Female
 Address _____
 City _____ State _____ ZIP _____
 Email _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Occupation _____ Employer Name _____ Employer City _____

COMPLETE FOR DEPENDENT COVERAGE (Dependent children may be covered to age 26)

NAME	GENDER	BIRTHDATE
Spouse		
Child		
Child		
Child		
Child		
Child		

AGENT INFORMATION
 Name Douglas Gulletson
 I.D. Number 82351
 Phone 480-633-9500

PLAN START DATE
 1st day of _____ 20____

(Attach a separate page for additional dependents)

PLEASE ATTACH A VOIDED CHECK IN SPACE

If paying by checking or savings account.
 Do not attach a deposit slip.

Please choose one of the following payment options.

OPTION 1 Direct Checking or Savings Payment Authorization Form
 I authorize the company to initiate entries to debit my account to payment of plan Monthly Annually
 Account Type Checking Savings Bank or Credit Union
 Billable Premium \$ _____ Authorization to draft initial premium Yes
 Full Name (PLEASE PRINT) _____ Signature _____

OPTION 2 Direct Credit or Debit Card Payment Authorization Form
 I authorize the company to initiate entries to debit my account for payment of plan Monthly Annually
 Card Type VISA Mastercard Discover American Express
 Card # _____ Expiration Date _____ ZIP _____
 Billable Premium \$ _____ Authorization to draft initial premium Yes
 Full Name (PLEASE PRINT) _____ Signature _____