



**Item # 3. Exclusions:**

a) Classes, include reason for exclusion, e.g., employees covered by Dental HMO, Prepaid or Union which is excluded for benefits:

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b) Locations: (identify location, city and state):

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**Item #4. Subsidiary and /or affiliated companies to be insured: (list names and locations):**

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**Item #12. Prior Dental Coverage**

Name of carrier(s): \_\_\_\_\_

Policy Number(s): \_\_\_\_\_

Effective Date: \_\_\_\_\_

Termination Date: \_\_\_\_\_

**Additional remarks:**

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