LINDSEY WILSON UNIVERSITY
PARAMOUNT DENTAL SELECTION FORM
FOR PLAN YEAR 2025

I hereby elect the following dental plan for the 2025 plan year.

☐	Single Core Plan MO	$16.57
☐	Single Buy Up Plan MO	$26.45
☐	Family Core Plan MO	$60.20
☐	Family Buy Up Plan MO	$100.46
☐	EE + Spouse Core Plan	$36.50
☐	EE + Spouse Buy Up Plan MO	$59.64
☐	EE + Child(ren) Core Plan	$40.18
☐	EE + Child(ren) Buy Up Plan	$65.45

☐	Single Core Plan BW	$8.29
☐	Single Buy Up Plan	$13.23
☐	Family Core Plan BW	$30.10
☐	Family Buy Up Plan	$50.23
☐	EE + Spouse Core Plan	$18.25
☐	EE + Spouse Buy Up Plan BW	$29.82
☐	EE + Child(ren) Core Plan BW	$20.09
☐	EE + Child(ren) Buy Up Plan	$32.73

☐ I waive participation in the 2025 dental insurance plan year.

_____ _____

Print Name Employee L#

_____ _____

Signature Date

insuringsmiles.com
PO Box 659 Evansville, IN 47704-0659
800-727-1444 Fax: 812-424-2096

HRI DENTAL & VISION

ENROLLMENT APPLICATION

ALL INFORMATION IS REQUIRED TO COMPLETE ENROLLMENT, MAKE CHANGES AND PROCESS CLAIMS

Group Legal Name: Lindsey Wilson University	**Group Number:**	**Site Location:**	**Plan:** ☐ Core ☐ Buy-Up

ADD	**TERM**	**UPDATE**
Coverage Effective Date: ___________	Coverage Termination Date: __________	Event Date (if applicable): _____________
☐ Open Enrollment	☐ Open Enrollment	☐ Name Change
☐ New Hire	☐ Employment Termination	☐ Social Security Number
☐ Coverage Lost	☐ Coverage Gained	☐ Date of Birth
☐ Marriage	☐ Death	☐ Address
☐ Divorced or Legal Separation	☐ Reduction of Hours Worked	☐ Coordination of Benefits
☐ Birth/Adoption	☐ Divorced or Legal Separation	☐ Disability
☐ COBRA (if applicable)	☐ Over Age Limit	☐ Full-Time Student Status
	☐ No Longer Full-Time Student	
	☐ COBRA (if applicable)	

EMPLOYEE	**PRODUCT**				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental and Vision ☐ Waive	Social Security Number	Employee Hire Date		
		Last Name	First Name	MI	Birth Date
PREFERRED LANGUAGE		Home Address	City	State	Zip
☐ English ☐ Spanish	☐ Vietnamese ☐ Other ____________	Phone Number	Email Address		

SPOUSE / PARTNER	**PRODUCT**				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental and Vision ☐ Waive	Social Security Number	Birth Date	☐ Disability ☐ Full-Time Student	Other Dental Coverage? ☐ Yes ☐ No
		Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No
PREFERRED LANGUAGE		Phone Number	Email Address		
☐ English ☐ Spanish	☐ Vietnamese ☐ Other ____________				

DEPENDENT	**PRODUCT**				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental and Vision ☐ Waive	Social Security Number	Birth Date	☐ Disability ☐ Full-Time Student	Other Dental Coverage? ☐ Yes ☐ No
		Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No
PREFERRED LANGUAGE		Phone Number	Email Address		
☐ English ☐ Spanish	☐ Vietnamese ☐ Other ____________				

DEPENDENT	**PRODUCT**				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental and Vision ☐ Waive	Social Security Number	Birth Date	☐ Disability ☐ Full-Time Student	Other Dental Coverage? ☐ Yes ☐ No
		Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No
PREFERRED LANGUAGE		Phone Number	Email Address		
☐ English ☐ Spanish	☐ Vietnamese ☐ Other ____________				

DEPENDENT	**PRODUCT**				
☐ Add ☐ Term ☐ Update	☐ Dental Only ☐ Vision Only ☐ Dental and Vision ☐ Waive	Social Security Number	Birth Date	☐ Disability ☐ Full-Time Student	Other Dental Coverage? ☐ Yes ☐ No
		Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No
PREFERRED LANGUAGE		Phone Number	Email Address		
☐ English ☐ Spanish	☐ Vietnamese ☐ Other ____________				

Please sign and date second page.

AUTHORIZATION AND ACKNOWLEDGMENT: I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued. All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form. I understand that my nonpublic health information cannot be disclosed without my express, written permission. I understand that by signing this form I am authorizing the necessary premium deductions from by salary or wages for the coverage I have selected.

For Indiana Residents: A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For Iowa and Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer submits an application or files a claim containing a false deceptive statement is guilty of insurance fraud.

Employee_____ Date _____

Employer Benefits Administrator/Authorized Agent_____ Date _____

Core Plan

Product Summary Guide for Lindsey Wilson University, Inc.

100/50/50 (DHO 2)

Your rates:

Employee Only:	$15.78
Employee + Spouse:	$34.76
Employee + Child(ren):	$38.27
Employee + Family:	$57.33

Plan Annual Maximum Benefit:	$1,000	
Diagnostic & Preventive	**In Network**	**Out of Network***
Exams – periodic, limited, comprehensive	Covered at 100%	Covered at 100%
Radiographs – full mouth series, panoramic, bitewings	Covered at 100%	Covered at 100%
Topical Fluoride - Age 19	Covered at 100%	Covered at 100%
Routine teeth cleaning	Covered at 100%	Covered at 100%
Sealants	Covered at 100%	Covered at 100%
Restorative & Prosthodontics		
Fillings - silver or white (anterior and posterior teeth)	Covered at 50%	Covered at 50%
Protective restorations	Covered at 50%	Covered at 50%
Oral Surgery		
Simple extractions	Covered at 50%	Covered at 50%
Impactions	Covered at 50%	Covered at 50%
Surgical extractions	Covered at 50%	Covered at 50%
Deductible (Not applicable on Diagnostic & Preventive):	**None**	**None**

*In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. If a statement in this summary conflicts with a statement in the Certificate, the terms of the Certificate will control. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in your Certificate, which is available on our website or by calling 800-727-1444.

To find a dentist visit: InsuringSmiles.com/FindADentist

HRI DENTAL &VISION

Buy Up

Product Summary Guide for Lindsey Wilson University 2025

100/100/60 IN - 100/80/50 OUT (Custom)

Your rates:

Employee Only:	$ 26.45
Employee + Spouse:	$ 59.64
Employee + Child(ren):	$ 65.40
Employee + Family:	$100.46

Plan Annual Maximum Benefit:	$1,000	
Diagnostic 8i Preventive	**In Network**	**Out of Network***
Exams - periodic, limited, comprehensive Radiographs-	Covered at 100%	Covered at 100%
full mouth series, panoramic, bitewings Fluoride	Covered at 100%	Covered at 100%
Routine teeth cleaning	Covered at 100%	Covered at 100%
Sealants	Covered at 100%	Covered at 100%
	Covered at 100%	Covered at 100%
Restorative & Prosthodontics		
Fillings - silver or white (anterior and posterior teeth)	Covered at 100%	Covered at 80%
Core build ups	Covered at 60%	Covered at 50%
Crowns - porcelain, ceramic, stainless steel	Covered at 60%	Covered at 50%
Protective restorations	Covered at 60%	Covered at 50%
Removable dentures	Covered at 60%	Covered at 50%
Endodontics 81 Periodontics		
Root canal therapy - anterior, posterior Root canal	Covered at 60%	Covered at 50%
therapy - retreatment Scaling and root planing Full	Covered at 60%	Covered at 50%
mouth debridement Periodontal maintenance	Covered at 60%	Covered at 50%
	Covered at 60%	Covered at 50%
	Covered at 60%	Covered at 50%
Oral Surgery		
	Covered at 100%	Covered at 80%
	Covered at 60%	Covered at 50%
Simple extractions Impactions Surgical extractions	Covered at 60%	Covered at 50%
Miscellaneous		
Emergency palliative treatment Anesthesia - general	Covered at 60%	Covered at 50%
and IV sedation Athletic mouthguards	Covered at 60%	Covered at 50%
	Covered at 60%	Covered at 50%
Deductible (Not applicable on Diagnostic & Preventive):	**None**	**None**
Lifetime Orthodontic Benefit (Child Only):	**$1,000**	

Procedures listed herein are payable up to the lifetime maximum benefit, not to exceed the maximum monthly installment. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhausted his/her lifetime maximum benefit under any Plan, additional charges will be excluded.

Limited Orthodontic Treatment

Interceptive Orthodontic Treatment

Comprehensive Orthodontic Treatment

Treatment to Control Harmful Habits

*In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. If a statement in this summary conflicts with a statement in the Certificate, the terrns of the Certificate will control. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in your Certificate, which is available on our website or by calling 800-727-1444.

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