

# **UNL Dental Shield 2.0 Underwriting Guide**

Base Plan: \$1,000-\$5,000 (OH and PA \$3,000 Maximum) Ages: 18-89 Child Rider: 0-17

1. The applicant must be a U.S. citizen or hold a "green card" (permanent resident of US). We will not consider any applicant that has a temporary visa, work or otherwise. The applicant also must have a valid social security number. We will not consider any applicant without one.

2. The agent must be health licensed and use the state approved application in the state where the applicant has permanent residency.

3. Power of Attorney/Guardianship is not accepted for this product (except in NE).

4. If the application is over 31 days old when received by the Company, a new currently dated Application will be required.

5. The effective date cannot be more than 90 days from the application date or prior to the application date.

6. The draft date should be the same as the effective date but if not, it can't be more than 15 days past the effective date.

7. No credit or debit cards allowed for this plan.

8. Cannot have multiple concurrent Dental-Vision policies, or Dental-Vision rider as well as a Dental-Vision Stand-Alone policy. This includes both companies, UNL and GTL. Only one dental plan or rider inforce at the same time is allowed.

# **Dental Continuous Coverage Requirements:**

- The prior coverage must be under a fully insured individual or employer group dental plan
- The prior coverage may be through Indemnity (non-network), PPO, or HMO type of products
- The prior coverage must have been effective for at least 12 months
- The prior coverage is allowed to be from 2 plans. For example: client had an employer dental plan 1/1/24 – 6/1/24 then switched to a UNL dental from 6/1/24 – 1/1/25. If the client wanted to upgrade their dental to a higher benefit, we would be able to waive the waiting period since they

did have 12 months combined between the employer plan and the UNL plan.

 No more than a 63-day gap is allowed between the termination date of prior coverage and effective date of UNL coverage

UNL will waive applicable waiting periods for insureds that present proof of qualified prior dental insurance coverage. Please *note*, *Underwriting will allow such proof to be supplied after the application process, but we encourage agents/applicants to provide such proof as early as possible. Supporting documents should be emailed to: <u>DentalProof@unlinsurance.com</u> or faxed to 847-699-0229. Please make sure the policy number is referenced (if available).* 

# Acceptable Proof of Qualified Prior Coverage\*:

- Letter or Certificate from prior carrier on carrier letterhead
- Copy of policy, Copy of ID Card, Premium Billing Notice

#### The proof must include the following:

- Carrier name (proper letterhead)
- Effective Date of coverage and proof of current status
- Name(s) of covered individual(s)
- Type of coverage (ex: PPO, HMO, Indemnity)
- Annual maximum and coinsurance

# Please note: Medicare/Medicaid are not acceptable as qualified prior coverage.

\*All proof of prior coverage is subject to UNL approval.

# **Replacement Guidelines:**

#### **External replacements:**

Please submit replacement form if required by your state.

#### Internal replacements:

In general, we do not permit replacement of another UNL agent's business. Contact our Agency Department if you have any questions regarding these types of replacements. The new application must be from the same writing agent. If approved by Underwriting, we will treat this as a replacement, pay renewal only.

### **Increase of Benefits Guidelines:**

We will allow the base plan to be increased under the following conditions:

- Increase must be from the same writing agent as existing.
- Policy must be inforce for a minimum of 12 months.
- •Replacement question must be answered YES, referencing existing plan.

•New application to increase benefits, if approved by underwriting, will be treated as a cancel/rewrite.

# **Decrease of Benefits Guidelines:**

A written request from the Insured or Policy Owner is required to decrease benefits. The request must include a wet signature.

## **Reinstatement Guidelines:**

A policy can be considered for reinstatement (subject to a reinstatement application) if not lapsed more than 6 months. After 6 months, a policy cannot reinstate and must reapply for a new coverage.

A new UNL Dental Shield 2.0 application submitted for Kathi Doe.

United National Life Insurance Company of America 1275 Milwaukee Avenue Glenview, Illinois 60025 (800) 207-8050 Dental Sh Application for: Limited Benefit Po	
If an Increase of Benefits is requested, please list UN	erage O Increase of Benefits _ policy/certificate number(s) affected: <b>:</b> O <b>AGENT</b> O <b>INSURED</b>
Proposed Insured 1 First NameKathi	M.ILast NameDoe
Soc. Security # <u>987-65-4321</u> Age _40	Date of Birth 01 / 29 / 1985 ○ Male ● Female
Address	
Home Address 1275 Milwaukee Ave	City_GlenviewState_ILZip_60025

#### Proof of prior coverage documentation must include the following:

- •Carrier Name (proper letterhead)
- •Effective Date of coverage and proof of current status
- •Name(s) of covered individual(s)
- •Type of coverage: Dental (ex: PPO, HMO, Indemnity (non-network)

# Example of acceptable proof of prior coverage:



Welcome, John Doe!

#### In Force Health

Address:	275 Milwaukee Ave	Policy Status:	Active
G Home Phone:	Tenview, IL 60025		
Effective Date:	1/1/2024		
Policy Number:			
Plan:	PLATNIUM DENTAL 1000 ANNUAL N	AX/80% COINS	
Written Date:	12/21/2023		
Mode Premium:	\$93.38	Paid To Date:	3/1/2025
Annual Premium:	\$1,125.02	Last Activity Date:	2/3/2025
Billing Mode:	Monthly	Suspense Money:	
Billing Form:	PAC	Policy Fee:	
Agent Information:	BAA Status Policy Access E-Mai	il Address	
Name		annone annone annone anno anno anno anno	
Name K Agent	is a Business Associate Agent has access to this policy		
Name K Agent		1	
Name K Agent	is a Business Associate Agent has access to this policy	3	

KATH Spous	e e Controlo F Z			
11-07-84				
Benefit intormat	••••••			
Nar DO	R Benefits	Effective Date	Effective DateAmountRate	
JOHN 11-07-84	PLATNIUM DENTAL 1000 ANNUAL MAX/80% COIN	IS 01-01-2024	77.80	
JOHN	CALENDAR YR MAXIMUM CARRYOVER RIDER	01-01-2024	15.58	
KATHE 01-29-8	PLATNIUM DENTAL 1000 ANNUAL MAX/80% COIN	IS 01-01-2024		
KATHF 01-29-8	CALENDAR YR MAXIMUM CARRYOVER RIDER	01-01-2024	0.00	

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This proof of prior coverage provides all the required elements:

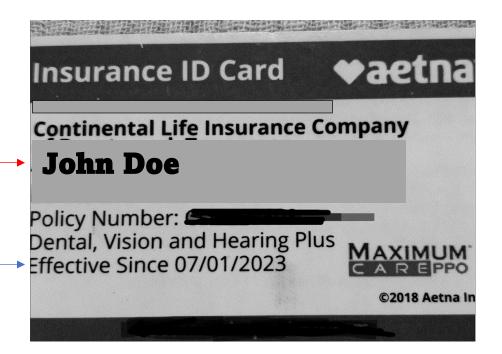
\* Proper letterhead.

JOHN

- \* Lists the Proposed Insured as a covered dependent.
- \* Includes the effective date and paid-to-date of the policy.
- ★Includes the type of coverage

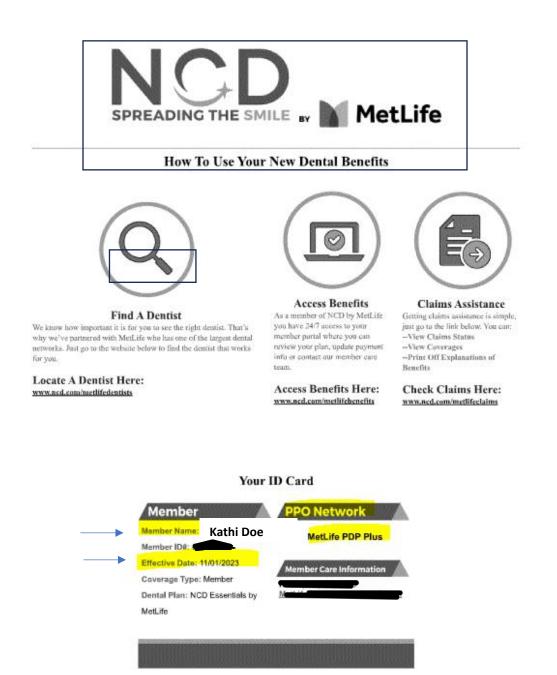
Primary Insured Output

Example of what is NOT acceptable as proof of prior coverage:



Why? The proposed Insured is Kathi Doe. This ID Card does not prove Kathi is a covered dependent under the policy. Also, although an effective date of coverage is provided, it does not prove current status of the policy.

Example of acceptable proof of prior coverage that requires additional information:



Although this example provides most of the required elements, it does not provide proof of current policy status. We know the plan became effective 11/1/2023, but is it currently Active? Terminated? There is no "date" to prove recent status. Documentation must prove prior coverage has been inforce for a minimum of 12 months. If the prior plan is terminated, we need to verify the new dental application is received within 63-days from the date of termination. We would need to request additional information to verify prior coverage information. In this example, a copy of the latest billing notice may suffice as additional proof.