WASHINGTON

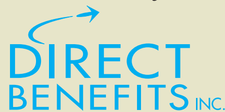
Employer Funded or Voluntary Group Dental Insurance Plan

Underwritten and administered by:

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

10901 Red Circle Drive
Minnetonka, MN 55343-9137

Distributed by:



Plan Coordinator:

Direct Benefits, Inc.
325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 • 800.620.5010
www.spiritdental.com

Choose Your Own Dentist

No Waiting Period for Preventive Services

For Employers 2-149

Credit for Prior Coverage Available

Optional Orthodontia Coverage

$1,000 or $1,500 Annual Maximums

S11729 (exp. 07/2016)

GOLD

Dental Insurance for employer groups with 2+ lives

Washington

- Option available to receive Credit for Prior Coverage
- Dental rate discount for 50% voluntary participation
- Option of Employer Funded or Voluntary contribution
- Freedom to use any Dentist

Class A - Preventive	
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments and Sealants (under age 16), Space Maintainers), bitewing x-rays	100%
Waiting Period	None
Class B - Basic	
X-rays, Fillings, Simple Extractions	80%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	None
Class C - Major	
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures	50%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	12 Months
Class D - Orthodontics	
Straightening of Teeth (for children under age 19)	50%
Deductible—Each Calendar Year per Insured*	None
Waiting Period	12 Months
Class E - TMJ	
Diagnosis and treatment of temporomandibular joint disorder	50%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	12 Months
Calendar Year Maximums	
Calendar Year Maximum for Classes A, B and C Combined	$1,500
Calendar Year Maximum for Class D – Ortho Services	$500
Calendar Year Maximum for Class E – TMJ Services	$1,000
Lifetime Maximum Per Child for Class D – Ortho Services	$1,000
Lifetime Maximum Per Person for Class E – TMJ Services	$5,000

*Class B, C & E Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.

CREDIT FOR PRIOR COVERAGE

A group with current dental coverage may choose to purchase the option to receive Credit for Prior Coverage (CPC) toward satisfaction of any waiting period or graded benefit year co-insurance. Credit may be given for the length of time an employee was covered under the employer's prior dental Insurance plan, provided there is no interruption in coverage between the prior plan and the replacement plan. The prior coverage must be similar in plan design to receive CPC. For example, if the prior plan did not cover Class C - Major services, CPC is not applied to Major services.

Employer Paid plans: CPC is given at the group level based on the length of time the employer carried the previous coverage. In order to receive CPC the employee must have been covered by the employer's previous plan. Any new employee and/or dependents added subsequent to the group's effective date of this coverage will not receive CPC.

Voluntary Plans: CPC is given individually to each person (employee, spouse or child) covered. Any new employee and/or dependents added subsequent to the group's effective date of this coverage will not receive CPC.

Underwritten by Security Life Insurance Company of America, 10901 Red Circle Drive, Minnetonka, Minnesota, 55343

SILVER

Dental Insurance for employer groups with 2+ lives

Washington

- Option available to receive Credit for Prior Coverage
- Dental rate discount for 50% voluntary participation
- Option of Employer Funded or Voluntary contribution
- Freedom to use any Dentist

Class A - Preventive	
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments and Sealants (under age 16), Space Maintainers, bitewing x-rays	100%
Waiting Period	None
Class B - Basic	
X-rays, Fillings, Simple Extractions	80%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	None
Class C - Major	
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures	50%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	12 Months
Class D - TMJ	
Diagnosis and treatment of temporomandibular joint disorder	50%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	12 Months
Calendar Year Maximums	
Calendar Year Maximum for Classes A, B and C Combined	$1,500
Calendar Year Maximum for Class D – TMJ Services	$1,000
Lifetime Maximum Per Person for Class D – TMJ Services	$5,000

*Class B, C & D Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.

CREDIT FOR PRIOR COVERAGE

A group with current dental coverage may choose to purchase the option to receive Credit for Prior Coverage (CPC) toward satisfaction of any waiting period or graded benefit year co-insurance. Credit may be given for the length of time an employee was covered under the employer's prior dental Insurance plan, provided there is no interruption in coverage between the prior plan and the replacement plan. The prior coverage must be similar in plan design to receive CPC. For example, if the prior plan did not cover Class C - Major services, CPC is not applied to Major services.

Employer Paid plans: CPC is given at the group level based on the length of time the employer carried the previous coverage. In order to receive CPC the employee must have been covered by the employer's previous plan. Any new employee and/or dependents added subsequent to the group's effective date of this coverage will not receive CPC.

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BRONZE

Dental Insurance for employer groups with 2+ lives

Washington

Spirit DENTAL

- Option available to receive Credit for Prior Coverage
- Option of Employer Funded or Voluntary contribution
- Dental rate discount for 50% voluntary participation
- Freedom to use any Dentist

Class A - Preventive	
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (under age 16), bitewing x-rays	80%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	None
Class B - Basic	
X-rays, Fillings, Simple Extractions, Space Maintainers, Endodontics, Periodontics, Sealants (under age 16)	50%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	None
Class C - Major	
Oral Surgery, Crowns, Bridges, Dentures	50%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	12 Months
Class D - TMJ	
Diagnosis and treatment of temporomandibular joint disorder	50%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	12 Months
Calendar Year Maximums	
Calendar Year Maximum for Classes A, B and C Combined	$1,000
Calendar Year Maximum for Class D – TMJ Services	$1,000
Lifetime Maximum Per Person for Class D – TMJ Services	$5,000

*Class A, B, C & D Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.

CREDIT FOR PRIOR COVERAGE

A group with current dental coverage may choose to purchase the option to receive Credit for Prior Coverage (CPC) toward satisfaction of any waiting period or graded benefit year co-insurance. Credit may be given for the length of time an employee was covered under the employer's prior dental Insurance plan, provided there is no interruption in coverage between the prior plan and the replacement plan. The prior coverage must be similar in plan design to receive CPC. For example, if the prior plan did not cover Class C - Major services, CPC is not applied to Major services.

Employer Paid plans: CPC is given at the group level based on the length of time the employer carried the previous coverage. In order to receive CPC the employee must have been covered by the employer's previous plan. Any new employee and/or dependents added subsequent to the group's effective date of this coverage will not receive CPC.

Voluntary Plans: CPC is given individually to each person (employee, spouse or child) covered. Any new employee and/or dependents added subsequent to the group's effective date of this coverage will not receive CPC.

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DENTAL EXPENSES NOT COVERED

The Policy covers services and procedures as described in the Coverage Schedule. Your coverage, under the policy, does not cover any miscellaneous or separate expense not considered a covered service or procedure. No benefits will be paid for expenses incurred:

- For overdentures and associated procedures;
- For charges in excess of those considered Reasonable and Customary;
- For cosmetic procedures;
- For the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
- For implants; and for: replacement of lost or stolen appliances; replacement of retainers; athletic mouthguards; precision or semi-precision attachments; or denture duplication;
- For oral hygiene instructions; and for: plaque control; completion of a claim form; acid etch; broken appointments; prescription or take-home fluoride; or diagnostic photographs; diagnostic photographs;
- For initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost;
- For addition of teeth to existing partial denture;
- For services not completed by the end of the month in which coverage ends;
- For procedures that are begun, but not completed;
- For services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
- For services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
- For a condition covered under any Worker's Compensation Act or similar law;
- For the treatment of cleft palate and anodontia;
- For Orthodontia, unless otherwise specifically covered in your policy;
- Prior to the date the Insured is covered under the Policy;
- For hospital services.

UNDERWRITING GUIDELINES

ELIGIBLE EMPLOYEES

An individual employed by a participating employer who works 20 hours or more per week, and who is considered an employee for Social Security purposes. Partners and Proprietors are also considered to be eligible employees.

ELIGIBLE DEPENDENT

Eligible dependent is any of the following persons:

- Your spouse/state registered Domestic Partner, and
- Your child including a child of a state registered Domestic Partnership), from birth to age 26.
- Each child (including a child of a state registered Domestic Partnership) at least 26 years of age who is dependent upon You for support because he is incapable of self-sustaining employment by reason of developmental disability or physical handicap; who was incapacitated and insured under the Policy on his 26th birthday; and who continues to be incapacitated beyond his 26th birthday.

EMPLOYER RESTRICTIONS

This insurance plan is only available to employers that have been in business more than one year.

Most Firms will qualify for this plan; however, coverage is not available to:

- Groups funded by the government or any government agency
- Groups that are home based
- Groups that are seasonal in nature
- Groups with more than 90% family content
- Dental offices

This list of ineligible Firms is representative only and not all-inclusive.

GENERAL INFORMATION

PREMIUMS, RENEWABILITY

Applicable Dental Premium Rates are guaranteed for each Employer Group for 12 months from date of issue. Thereafter, rates are subject to change in accordance with the Master Policy. Coverage is renewable as long as eligibility criteria are satisfied and premiums are paid when due.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following dates: (a) the last day of the month in which You cease to be eligible for coverage; (b) the last day of the month in which Your Dependent is no longer a dependent as defined; (c) subject to the Grace Period, the last day of the month for which a premium has been paid by you or on your behalf; or (d) the date the Master Policy ends.

COORDINATION OF BENEFITS

This insurance plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits.

PARTICIPATION DISCOUNT

In the event the final dental employee participation reaches the greater of 3 employees or 50% of the eligible employees, your monthly premium rates charged may be reduced by 10%. Final approval of this discount is to be made by the Company. This discount does not apply to the Employer Paid rates.

EFFECTIVE DATE

The insurance for its current employees will be effective on the date approved by the insurance company. Future new employees will become insured on the first of the month following the completion of the probationary period selected by the employer. A completed enrollment form must be received within 31 days of new employee eligibility. An employee who does not enroll when initially eligible is considered a "late entrant." A late entrant is eligible to enroll in the program as a "new employee" on the Plan's Anniversary Date or immediately if a qualifying event occurs.

REASONABLE AND CUSTOMARY

Reasonable and Customary means the usual, customary and regular charges for the area where such expenses are incurred.

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Dental Policy Form GP1000-WA. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product is subject to individual state regulations.

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325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 | 800.620.5010
info@spiritdental.com

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

GOLD Group Dental Insurance

Washington rates effective April 1, 2014 - December 31, 2014

Spirit DENTAL

Follow the steps below to find your **Washington** monthly policy rate:

1 Find your Area by locating the first 3 digits of your zip code

	Zip	Area	MY AREA #
Washington	980, 983-984	5	
	981	7	
	986, 990-992	3	
	All Others	4	

2 Find your dental rate by your Area, Contribution, and Credit for Prior Coverage option

Voluntary

Without Credit for Prior Coverage	Area 3	Area 4	Area 5	Area 7	DENTAL RATES *per employee*
Employee Only	$42.41	$46.60	$51.26	$61.98	
Employee + Spouse**	$84.81	$93.20	$102.52	$123.96	
Employee + Child(ren)	$98.84	$107.56	$117.25	$139.54	
Employee + Family	$150.58	$164.42	$179.80	$215.17	

With Credit for Prior Coverage	Area 3	Area 4	Area 5	Area 7	DENTAL RATES *per employee*
Employee Only	$48.77	$53.59	$58.95	$71.27	
Employee + Spouse**	$97.53	$107.18	$117.90	$142.55	
Employee + Child(ren)	$114.72	$124.75	$135.90	$161.53	
Employee + Family	$174.22	$190.14	$207.83	$248.50	

Employer Paid*

Without Credit for Prior Coverage	Area 3	Area 4	Area 5	Area 7	DENTAL RATES *per employee*
Employee Only	$36.87	$40.52	$44.57	$53.89	
Employee + Spouse**	$73.75	$81.04	$89.14	$107.78	
Employee + Child(ren)	$85.94	$93.53	$101.96	$121.34	
Employee + Family	$130.94	$142.97	$156.34	$187.10	

With Credit for Prior Coverage	Area 3	Area 4	Area 5	Area 7	DENTAL RATES *per employee*
Employee Only	$42.41	$46.60	$51.26	$61.98	
Employee + Spouse**	$84.81	$93.20	$102.52	$123.96	
Employee + Child(ren)	$99.76	$108.48	$118.17	$140.46	
Employee + Family	$151.50	$165.34	$180.72	$216.09	

**Requires 75% employer contribution for employee only, or 50% employer contribution for employee + dependent.*

3 Find the monthly dental premium for your group

	Base Rate	Discount: 50% Participation***	Total Monthly Premium	# of Employees	Subtotal
Employee Only	$	x 0.90	= $	x =	$
Employee + Spouse**	$	x 0.90	= $	x =	$
Employee + Child(ren)	$	x 0.90	= $	x =	$
Employee + Family	$	x 0.90	= $	x =	$
				Total Dental Premium for Group	$

***Or state registered Domestic Partner.*
****Available for Voluntary participation only, for groups with 3+ employees or 50% participation, whichever is greater.*
Groups over 100 eligible employees must be submitted to the home office for review.

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

SILVER Group Dental Insurance

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	981	7	
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	All Others	4	

2 Find your dental rate by your Area, Contribution, and Credit for Prior Coverage option

Voluntary

Without Credit for Prior Coverage	Area 3	Area 4	Area 5	Area 7	DENTAL RATES *per employee*
Employee	$42.41	$46.60	$51.26	$61.98	
Employee + Spouse**	$84.81	$93.20	$102.52	$123.96	
Employee + Child(ren)	$88.20	$96.92	$106.61	$128.90	
Employee + Family	$139.94	$153.78	$169.16	$204.53	
With Credit for Prior Coverage	**Area 3**	**Area 4**	**Area 5**	**Area 7**	**DENTAL RATES *per employee***
Employee	$48.77	$53.59	$58.95	$71.27	
Employee + Spouse**	$97.53	$107.18	$117.90	$142.55	
Employee + Child(ren)	$101.43	$111.46	$122.61	$148.24	
Employee + Family	$160.93	$176.85	$194.54	$235.21	

Employer Paid*

Without Credit for Prior Coverage	Area 3	Area 4	Area 5	Area 7	DENTAL RATES *per employee*
Employee	$36.87	$40.52	$44.57	$53.89	
Employee + Spouse**	$73.75	$81.04	$89.14	$107.78	
Employee + Child(ren)	$76.69	$84.28	$92.71	$112.09	
Employee + Family	$121.69	$133.72	$147.09	$177.85	
With Credit for Prior Coverage	**Area 3**	**Area 4**	**Area 5**	**Area 7**	**DENTAL RATES *per employee***
Employee	$42.41	$46.60	$51.26	$61.98	
Employee + Spouse**	$84.81	$93.20	$102.52	$123.96	
Employee+ Child(ren)	$88.20	$96.92	$106.61	$128.90	
Employee + Family	$139.94	$153.78	$169.16	$204.53	

**Requires 75% employer contribution for employee only, or 50% employer contribution for employee + dependent.*

3 Find the monthly dental premium for your group

	Base Rate	Discount: 50% Participation***	Total Monthly Premium	# of Employees	Subtotal
Employee Only	$	x 0.90	= $	x =	$
Employee + Spouse**	$	x 0.90	= $	x =	$
Employee + Child(ren)	$	x 0.90	= $	x =	$
Employee + Family	$	x 0.90	= $	x =	$
				Total Dental Premium for Group	$

***Or state registered Domestic Partner.*
****Available for Voluntary participation only, for groups with 3+ employees or 50% participation, whichever is greater.*
Groups over 100 eligible employees must be submitted to the home office for review.

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

BRONZE Group Dental Insurance

Washington rates effective April 1, 2014 - December 31, 2014

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	Zip	Area	MY AREA #
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	981	7	
	986, 990-992	3	
	All Others	4	

2 Find your dental rate by your Area, Contribution, and Credit for Prior Coverage option

Voluntary

Without Credit for Prior Coverage	Area 3	Area 4	Area 5	Area 7	DENTAL RATES *per employee*
Employee Only	$30.04	$33.01	$36.31	$43.90	
Employee + Spouse**	$60.07	$66.01	$72.61	$87.79	
Employee + Child(ren)	$62.48	$68.66	$75.53	$91.32	
Employee + Family	$99.12	$108.92	$119.81	$144.86	
With Credit for Prior Coverage	**Area 3**	**Area 4**	**Area 5**	**Area 7**	**DENTAL RATES *per employee***
Employee Only	$34.54	$37.96	$41.76	$50.49	
Employee + Spouse**	$69.08	$75.91	$83.50	$100.96	
Employee + Child(ren)	$71.84	$78.95	$86.85	$105.00	
Employee + Family	$113.99	$125.26	$137.79	$166.60	

Employer Paid*

Without Credit for Prior Coverage	Area 3	Area 4	Area 5	Area 7	DENTAL RATES *per employee*
Employee Only	$26.12	$28.70	$31.57	$38.17	
Employee + Spouse**	$52.23	$57.40	$63.14	$76.34	
Employee + Child(ren)	$54.33	$59.70	$65.67	$79.40	
Employee + Family	$86.19	$94.71	$104.18	$125.96	
With Credit for Prior Coverage	**Area 3**	**Area 4**	**Area 5**	**Area 7**	**DENTAL RATES *per employee***
Employee Only	$30.04	$33.01	$36.31	$43.90	
Employee + Spouse**	$60.07	$66.01	$72.61	$87.79	
Employee + Child(ren)	$62.47	$68.65	$75.52	$91.30	
Employee + Family	$99.12	$108.92	$119.81	$144.86	

**Requires 75% employer contribution for employee only, or 50% employer contribution for employee + dependent.*

3 Find the monthly dental premium for your group

	Base Rate	Discount: 50% Participation***	Total Monthly Premium	# of Employees	Subtotal
Employee Only	$	x 0.90	= $	x =	$
Employee + Spouse**	$	x 0.90	= $	x =	$
Employee + Child(ren)	$	x 0.90	= $	x =	$
Employee + Family	$	x 0.90	= $	x =	$
				Total Dental Premium for Group	$

***Or state registered Domestic Partner.*
****Available for Voluntary participation only, for groups with 3+ employees or 50% participation, whichever is greater.*
Groups over 100 eligible employees must be submitted to the home office for review.

Security Life Insurance Company of America
10901 Red Circle Drive
Minnetonka, Minnesota 55343
800.233.0307

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

Group Application for Insurance: Spirit Dental

How to Enroll

1. Complete all sections of the Group Application for Insurance based upon the plan selected. Be sure to sign/date where applicable.
2. Obtain signed enrollment forms from each employee electing coverage. Review each enrollment form, completing the top section of each form with applicable employer information.
3. If prior dental plan credit is requested, attach copy of the most recent billing statement from the prior carrier indicating coverage for each employee. This statement must also include the effective date of the prior coverage from which appropriate credit shall be calculated.
4. Determine your initial monthly premium due, make check payable to: Security Life Insurance Company of America.
5. **Submit application, enrollment forms, prior plan details (if applicable), and initial premium check to:**

Direct Benefits
325 Cedar Street #800
St. Paul, MN 55101

Questions - Call 800.620.5010

The undersigned Employer hereby requests application, to insure eligible persons under the dental policy selected, and hereby accepts and agrees to be bound by the terms and conditions as now in effect, or hereafter may be modified. If accepted, the undersigned Employer agrees: (a) to make such benefits available to all present employees and all employees becoming eligible in the future; and (b) to make payroll deductions as required for the plan as are applicable to the employees. The undersigned Employer further agrees that only those full-time employees who meet the eligibility requirements are to be included, and that participation requirements must be met before the benefit plan can be made effective.

The employer agrees that not less than two (2) employees of the employer's eligible employees must be enrolled in the Security Dental Plan to prevent cancellation of coverage. This plan does not require any contribution from the employer. To be eligible for the Employer Paid premium rates illustrated, the employer agrees to contribute no less than 75% of the employee only premium or 50% of the combined employee/dependent premiums.

- **Effective Date:** The effective date of participating employer unit shall be limited to the first of the month.
- **Eligibility Date:** Eligibility for present employees will be the initial effective date, while new hires will be eligible on the first of the month following one month of continuous employment unless other provision have been agreed upon between the administrator and the participating employer unit.
- **Premiums:** Applicable premium rates are guaranteed to twelve (12) months from the employer's initial effective date. Thereafter, premium rates are subject to change in accordance with the policy.
- **Participation Discount:** In the event the final employee participation reaches the greater of 3 employees or 50% of the eligible employees, your monthly premium rates charged may be reduced by 10%. This discount does not apply to the employer paid rates. Final approval of this discount is to be made by the Company.

Employer Information

Name of Employer | Send Correspondence To

Address | City | State | Zip Code | Fax Number

Telephone Number | Nature of Business | ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other

Subsidiaries and Affiliates Included: ☐ Yes ☐ No

Name and Address of Subsidiaries & Affiliates whose Employees are to be Covered

Initial Probationary Period

(a) For current employees – NONE
(b) For future employees: _______ DAYS/MONTHS

New hires to be effective on the first of the month following probationary period.

Security Life Insurance Company of America
10901 Red Circle Drive
Minnetonka, Minnesota 55343
800.233.0307

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

Dental Application

☐ Gold ☐ Silver ☐ Bronze | ☐ Voluntary ☐ Employer Paid

Participation and Contributions *The undersigned Employer agrees to contribute:*

Employee	$	/OR	%
Employee/Spouse	$	/OR	%
Employee/Child(ren)	$	/OR	%
Employee/Family	$	/OR	%

There are initially _______ full-time employees which _______ are enrolled in this Insurance plan.

Current Dental Plan

Is this group currently enrolled under another group dental program?	☐ Yes ☐ No
Are Credit for Prior Coverage (CPC) Benefits requested?	☐ Yes ☐ No
Did you include a copy of the current Plan and a copy of the last billing?	☐ Yes ☐ No

The undersigned employer requests that benefits be made available to all employees subject to the following conditions:

(a) No coverage for any employees shall take effect until this agreement and the employee's individual enrollment forms are accepted by the Company and the initial premium paid; and
(b) Employer agrees to remit regularly, in advance, the required premium payments to the administrator and acknowledges and agrees that this plan is established under and is subject to the provision of the Employee Retirement Income Security Act (ERISA), as amended. The undersigned employer is the plan administrator as defined in ERISA, as amended.

Fraud Statement: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employer/Firm Name --

Date --

Authorized Signature --

Email --

Producer's Statement

I hereby certify that all the information contained in this Group Application for Insurance is correct to the best of my knowledge and I know nothing unfavorable about this entity or any individual proposed for participation. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the entity.

Producer Name		
Street Address		
City	St	Zip
Producer Phone #		
Producer Email		
Producer SS#/TIN#		
Appointed with Security Life? ☐ Yes ☐ No		
Producer Signature		

Security Life Insurance Company of America
10901 Red Circle Drive
Minnetonka, Minnesota 55343
800.233.0307

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

Group Enrollment Form: return completed form to your employer

EMPLOYER INFORMATION *(TO BE COMPLETED BY THE EMPLOYER)*

Name and Address of Employer or Organization (if applicable)	Full-Time Hire Date	FOR COMPANY USE ONLY
	Telephone Number	Effective Date: Plan Code: Group # / Division: CPT:

EMPLOYEE INFORMATION *(PLEASE PRINT CLEARLY)*

Coverage Election:	☐ Dental ☐ No coverage
I apply for coverage on:	☐ Employee Only ☐ Employee and Spouse/State Registered Domestic Partner ☐ Employee and Child(ren) ☐ Employee and Family

Last Name	First Name	Initial	Birth Date *M/D/Y*

Address	Telephone Number	Sex ☐ Male ☐ Female

City	State	Zip	Marital Status
	Washington		☐ Married ☐ Single ☐ State Registered Domestic Partner

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

LAST NAME (If Different)	FIRST NAME	INITIAL	SEX M/F	AGE	BIRTH DATE M/D/Y
Spouse/State Registered Domestic Partner					
Dependent					____/____/____
Dependent					____/____/____
Dependent					____/____/____

Please note: If additional dependent information is necessary, please attach a separate sheet of paper

1. Does your Spouse/State Registered Domestic Partner have a dental plan? ☐ Yes ☐ No	2. If answer to 1 is "yes", are dependents enrolled under Spouse's/State Registered Domestic Partner's plan? ☐ Yes ☐ No

Group Dental Coverage is issued to the Group Policyholder, insured by Security Life Insurance Company of America.

By my signature below, I hereby apply for the coverage or coverage's selected above. I certify I have read the applicable Fraud Notice below. I also hereby authorize payroll deductions from my earnings for any contributions required. This Authorization remains in effect until revoked by me in writing.

Fraud Notice: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee Signature --

Date --

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

Spirit Dental Payment Authorization Form

Group Name:

Monthly Premium (from Rate Sheet):

Method of Payment (select one)

CHECKING ACCOUNT (ACH)	CREDIT CARD	PAPER BILL
☐ **Monthly Bank Account Debit** *Submit 1 months premium and a voided check* ☐ **Quarterly Bank Account Debit** *Submit 3 months of premium and a voided check*	☐ **Monthly Credit / Debit Card** Please select your card type below and provide your credit card account information: ☐ Visa ☐ MasterCard ☐ Discover ____________________ Credit Card Number ____________ Expiration Date	☐ **Monthly Paper Bill** ** *Initial invoice will be for two months premium and then monthly after that.* ☐ **Quarterly (3 months) Paper Bill** ** *All invoices will be for 3 months and sent quarterly.* Paper billing begins on your policy effective date and we will provide you with an invoice of charges due for the insurance policy. ***Claims will not be processed until the initial payment is received.*

Authorization Agreement

I authorize Security Life Insurance Company of America to initiate electronic debit entries to my account chosen above for payment of my insurance premium. My account will be debited by the third business day of the month in which premium is due. I understand I will receive a notice if the amount changes. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of the US law. (Applies only to ACH and Credit Card options.)

I understand that in order to make changes to this authorization (such as a change in bank account, method of payment, or termination of payment) I need to give Security Life written notification at least 10 days prior to the next scheduled payment. I understand that the insurance plan may be cancelled by Security Life if any payment is dishonored by my bank for any reason. In the case of an NSF, I am liable for any fees my bank may charge me and may also be responsible for an NSF fee of up to $25 which may be automatically debited for each NSF.

Your Signature ______________________________ **Date** ________________

Submit Payment Form (must submit with Employer and Employee Applications)

MAIL	FAX
Direct Benefits | 325 Cedar St. #800 | St. Paul, MN 55101	651-649-3502

Spirit DENTAL

New Business Checklist

Please confirm that the following is submitted with all new cases.

- ☐ Completed Employer Application
- ☐ Completed Employee Enrollments
- ☐ First Month Premium (payable to Security Life Insurance Company of America)
- ☐ Producer Licensing Forms (if not previously contracted)
- ☐ Online Agent-generated Proposal (www.directbenefits.com/dental/181-spirit-calculator)

CREDIT FOR PRIOR COVERAGE (CPC)

Please confirm that all of the following documentation is provided prior to coverage on take-over cases:

- ☐ Copy of Prior Carrier's certificate, booklet or schedule of benefits
- ☐ Copy of Prior Carrier's most recent billing statement

After all of the information listed above is completed and signed send all original forms to:

Direct Benefits, Inc.
325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 • 800.620.5010
fax: 651-649-3502
info@directbenefits.com

Submission Date:

New Group Information should be postmarked no later than the end of the month to be effective by the first of the following month.