GEMSTAR℠ PPO 1500

dental and vision insurance kit

Good through December 31, 2013

BROUGHT TO YOU BY:

Agent Name

Phone Number | Email Address
Website

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

BROCHURE

RATES

EMPLOYER ELECTION

EMPLOYEE ENROLLMENT

GEMSTAR℠

PPO 1500 Dental Insurance for employer groups with 2+ lives

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

Class A - Preventive	PPO 1500
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (to age 16)	
Benefit Day 1	100%
Deductible—Lifetime per Insured	$50
Waiting Period	None
Class B - Basic	
X-rays, Fillings, Simple Extractions, Sealants (to age 16)	
Benefit Day 1	50%
Benefit After Year 1	60%
Benefit After Year 2	80%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	None
Class C - Major	
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures	
Benefit Day 1	30%
Benefit After Year 1	50%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	None
Class D - Orthodontics	
Straightening of Teeth (for children under age 19)	
Benefit Day 1	0%
Benefit After Year 1	50%
Deductible	None
Waiting Period	12 Months
Calendar Year Maximums	
Calendar Year Maximum for Classes A, B and C Combined	$1,500
Calendar Year Maximum for Class C – Major Services	$750
Calendar Year Maximum for Class D	$500
Lifetime Maximum Per Child for Class D	$1,000

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

- Freedom to use any Dentist – Network Options Available for Additional Savings
- Credit for prior coverage available
- Dental rate discount for 50% voluntary participation
- Rate discount for combined dental and vision package

Maximum Care Network

With over 200,000 dental locations nationwide, the Maximum Care Network can help you save up to 50% on routine and major dental procedures, in addition to helping you manage your annual maximums. Search providers at careington.com/co/maxcare. This option is not available in ID, NJ, VT or WA. Security Life will be held harmless in the event that the provider network does not have the appropriate state licensure or that the provider does not honor the network's discount.

Brought to you by:

Credit for Prior Coverage

If this plan is replacing an existing group dental plan (with comparable coverage) those employees (and their dependents) who were covered under the preceding plan will receive credit for the time covered towards this plan's waiting periods. Credit will be calculated based on the number of months each employee was covered under the prior plan. New employees (and dependents) joining the plan will be subject to the waiting periods. A copy of the group's prior plan and last billing statement showing those covered (and their prior plan effective date) must be provided with the group application to ensure proper credit is given.

DENTAL EXPENSES NOT COVERED

- 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, denture duplication;
- for missing tooth: when covered under your plan, benefits are provided for placement of dentures, fixed bridgework, implants or the addition of teeth to existing dentures only when the service includes replacement of a natural tooth extracted or lost while covered under this plan. This limitation ends after the individual receiving care has been covered under this plan for 36 consecutive months.
- 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;
- for services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us;
- 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 services that are generally considered by the dental profession as experimental or investigational;
- for the treatment of cleft palate and anodontia;
- for services or supplies payable under any medical expense plan;
- for orthodontia, unless included within Coverage Schedule;
- for services rendered prior to the date the Insured is covered under the Policy;
- for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD);
- for hospital services;
- if You voluntarily end Your insurance You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
- charges for infection control, sterilization, and waste disposal.

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, and
- Your unmarried child, from birth to age 26.
- Each unmarried child at least 26 years of age who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation 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

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

When a firm joins the Trust, 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.

NOT AVAILABLE IN CT, NY OR WA

The insurance plan provides for an increase in coinsurance levels based upon each Benefit Year of coverage. Benefit Year begins with each insured's effective date and continues for 12 months. Each primary insured and/or dependent will have his own Benefit Year beginning with his specific effective date of coverage.

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

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 GH-1112. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product is subject to individual state regulations. This product is subject to individual state regulations. The policyholder may be a trustee group policyholder in some states.

GEMSTAR℠

PPO 1500 Vision Insurance for employer groups with 2+ lives

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

- No waiting periods
- Rate discount for combined dental and vision package
- Additional network discounts available

Vision Benefits – In Network	9752007
EXAMINATION	
Frequency	Once every 12 months
Insureds Copay	$10
EYEGLASS LENSES	
Frequency	Once every 12 months
Insureds Copay	$10
FRAMES	
Frequency	Once every 12 months
Insureds Copay	$0
CONTACTS (in lieu of eyeglass lenses)	
Frequency	Same as eyeglass lenses
Insureds Copay	Same as eyeglass lenses

Vision Benefits – Out of Network	The plan will pay:
Eye Examination	$25
Single Vision Lenses	$20
Bifocal Lenses	$40
Trifocal Lenses	$50
Frames	$40
Contacts (in lieu of eyeglass lenses)	$70

Brought to you by:

WHAT THE BENEFITS INCLUDE

- **Eye Examination –** A routine, complete eye examination, refraction and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures which are the responsibility of the member.
- **Eyeglass Lenses –** Standard uncoated plastic lenses of any size or power.
- **Frames –** Any frame up to a regular retail value of $100. Frames above $100 retail are available at an additional charge.
- **Contact Lenses –** Any pair of contact lenses up to a regular retail price of $100 obtained from a network provider or the mail order program. Contact lenses above $100 are available at an additional charge.
- **LASIK –** Non-insured discount benefit. The EyeMed Access Network provides discounts to insureds interested in LASIK – a laser vision correction procedure. This non-insured benefit is offered at savings of 15% off the regular retail price or 5% off the promotional price when using the network.
- **2 year rate guarantee**
- **EyeMed Access Network –** EyeMed includes such familiar names as LenCrafters, Pearle Vision, Sears Optical and Target Optical along with thousands of independent optometrists, ophthalmologists and opticians. For more information or to find a participating doctor, call 866.723.0513 or visit **EnrollWithEyeMed.com/access**.
- **Additional Lens Option Benefits –** In network only, add to the lens price above and enjoy add-on benefits for a minimum copayment:

Add-Ons	Copayment
UV Coating	$15
Scratch Resistance	$15
Tint	$15
Polycarbonate	$40
Anti-Reflective	$45
Standard Progressive	$65
Other Add-Ons	20% Retail Discount

BENEFIT PROVISIONS, LIMITATIONS AND EXCLUSIONS

VISION EXPENSES NOT COVERED

Limitations – In no event will payment exceed the lesser of:

- The actual cost of covered Services or Materials; or
- the limits of the Policy, shown in this Schedule.

Exclusions – We will not cover:

- Orthoptic or vision training and any associated supplemental testing;
- plano lenses;
- lens coatings;
- two pairs of glasses, in lieu of bifocals or trifocals;
- medical or surgical treatment of the eyes;
- any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- any injury or illness when covered under any Workers Compensation or similar law, or which is work-related;
- no-line bifocal or progressive lenses;
- photo-chromatic lenses;
- sub-normal vision aids or non-prescription lenses;
- services rendered or Materials purchased outside the U.S. or Canada, unless: a. the Insured resides in the U.S. or Canada; and b. the charges are incurred while on a business or pleasure trip.
- charges in excess of the Usual and Customary charge for the Service or Materials;
- charges incurred after; a. the Policy ends; or b. the Insured's coverage under the Policy ends, except as stated in the Policy;
- experimental or non-conventional treatment or device;
- spectacle lens treatments or "add-ons", except solid tints (#1 and #2), and oversize lenses;
- high index lenses of any material type;
- lost or broken Materials, except when replaced at normal intervals when Services are available.

UNDERWRITING GUIDELINES

ELIGIBILITY

Rates are guaranteed for a period of TWO YEARS from the effective date. Full-time students up to age 25 are eligible as dependents. Annual open enrollment.

ELIGIBLE EMPLOYEE

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, and
- Your unmarried child, from birth to age 26.
- Each unmarried child at least 26 years of age who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation 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 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

This list of ineligible firms is representative only and not all-inclusive. Please see rate card for additional information.

GENERAL INFORMATION

PREMIUMS, RENEWABILITY

Applicable Vision Premium Rates are guaranteed for each Employer Group for 24 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 Plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits.

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.

NOT AVAILABLE IN NEW JERSEY, VERMONT OR WASHINGTON

Policy Series GH-1154 – GH-1157. This is only a Summary of Benefits. For complete information please see the Certificate of Insurance.

This brochure provides a very brief description of some important features of your Plan. It is not the Insurance Contract nor does it represent the Contract. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Vision Policy Form GH-1157 for all states except IL, IA & MN. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Vision Policy Form GH-1154 for IL, IA & MN. The policyholder may be a trustee group policyholder in some states.

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance poliy 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 GH-2300. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product is subject to individual state regulations.

GEMSTAR PPO 1500 MONTHLY PREMIUM RATES
For Effective Dates May 1, 2013 through December 31, 2013

Groups of over 100 eligible employees must be submitted to the home office for review.
Increase all rates 20% for schools and governmental bodies.

Employer paid rates require 75% employer contribution for employee only; or
50% employer contribution for Employee + Dependent

Group Dental Base Rates*		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Voluntary	Employee Only	$ 23.11	$ 25.23	$ 27.88	$ 30.63	$ 33.60	$ 37.10	$ 40.60	$ 44.73
	Employee+Spouse	$ 46.64	$ 51.20	$ 56.29	$ 61.90	$ 68.05	$ 74.94	$ 82.15	$ 90.63
	Employee+ Child(ren)	$ 55.23	$ 60.53	$ 66.36	$ 72.93	$ 80.35	$ 88.30	$ 96.99	$ 106.85
	Employee + Family	$ 83.63	$ 91.69	$ 100.70	$ 110.77	$ 121.90	$ 134.09	$ 147.23	$ 162.29
Employer Paid	Employee Only	$ 20.03	$ 21.94	$ 24.17	$ 26.61	$ 29.26	$ 32.22	$ 35.19	$ 39.01
	Employee+Spouse	$ 40.70	$ 44.52	$ 48.97	$ 53.85	$ 59.25	$ 65.19	$ 71.55	$ 78.86
	Employee+ Child(ren)	$ 47.91	$ 52.58	$ 57.66	$ 63.60	$ 69.96	$ 76.85	$ 84.27	$ 93.07
	Employee + Family	$ 72.72	$ 79.82	$ 87.56	$ 96.46	$ 106.11	$ 116.60	$ 128.05	$ 141.09

Group Vision Base Rates*		
Voluntary	Employee Only	$ 7.50
	Employee+Spouse	$ 14.10
	Employee+ Child(ren)	$ 12.20
	Employee + Family	$ 20.10
Employer Paid	Employee Only	$ 6.60
	Employee+Spouse	$ 12.20
	Employee+ Child(ren)	$ 10.50
	Employee + Family	$ 17.30

DENTAL ZIP CODE AREA CHART

State Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area	State & Zip	Area
Alabama		**California**		**Dist Columbia**	6	**Mississippi**		**Nevada**		**Rhode Island**	3	**Virginia**	
350-355	3	917-918	4	**Hawaii**	3	390-392	2	898	6	**South Carolina**	1	222-223	6
359	3	919-927	6	**Idaho**	1	All Others	1	All Others	4	**Tennessee**		224-225	1
All Others	1	930-934	6	**Indiana**		**Missouri**		**New Mexico**		373-374	2	228-229	2
Alaska		939	6	463-464	2	640-641	2	881	2	All Others	1	230-232	1
995-996	8	943-948	4	473	3	644-649	2	882	5	**Texas**		233-237	5
All Others	6	949, 961	6	All Others	1	All Others	1	All Others	1	751-753	3	240-244	2
Arizona		956-958	3	**Kansas**		**Montana**		**Ohio**	1	754	4	All Others	4
856-857	2	959	4	660-662	2	590-591	1	**Oklahoma**		756-757	1	**West Virginia**	
864	2	All Others	5	All Others	1	599	2	740-743	2	776-777	1	255-257	4
All Others	1	**Colorado**		**Massachusettes**	5	All Others	3	All Others	1	All Others	2	262-265	3
Arkansas	1	803	4	**Michigan**		**Nebraska**	1	**Oregon**		**Utah**	1	All Others	2
California		808-810	4	480-483	2	**Nevada**		977	3	**Virginia**		**Wisconsin**	1
900-905	7	All Others	1	490-491	2	890-891	2	978	1	201	5	**Wyoming**	1
906-914	6	**Delaware**	2	488-489	3	894-895	6	All Others	2	220-221	5		
915-916	8			All Others	1								

*****If the group is electing both dental and vision coverage, the base rates may be reduced by 5%. In order to qualify for this discount at least 2 employees must elect dental coverage and at least 2 employees must elect vision coverage.***

Determine your monthly dental premium	*Dental Base Rates	**Discount for electing both dental and vision ☐ Yes ☐ No	Add for Waiting Period Credit? ☐ Yes ☐ No	Discount for 50% Participation? (Voluntary Only) ☐ Yes ☐ No	Dental Monthly Premium Total	# of Employees	Dental Subtotal
Employee Only	$	X.95	X1.14	X.90	$		$
Employee + Spouse	$	X.95	X1.14	X.90	$		$
Employee +Child(ren)	$	X.95	X1.14	X.90	$		$
Employee + Family	$	X.95	X1.14	X.90	$		$
					Initial Dental Premium Due		$

Determine your monthly vision premium	*Vision Base Rates	**Discount for electing both dental and vision ☐ Yes ☐ No	Vision Monthly Premium Total	# of Employees	Vision Subtotal
Employee Only	$	X.95			$
Employee + Spouse	$	X.95			$
Employee +Child(ren)	$	X.95			$
Employee + Family	$	X.95			$
			Initial Vision Premium Due		

Initial Remittance
Dental $
Vision $
Total Due $
Payable to Security Life Insurance Co of America

GEMSTAR PPO 1500

EMPLOYER ELECTION FORM

How to enroll…

1) Complete all sections of the Employer Election Form based upon the plan selected. Be sure to complete both sides of the election form and 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**

Authorization To Convert Your Check To An Electronic Funds Transfer Debit – By sending your check to us, you authorize **Security Life Insurance Company of America** to convert the check into an electronic funds transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment.

5) Submit Employer Election Form, Employee Enrollment Forms, Prior Plan details (if applicable), and initial premium check to:
Security Life Insurance Company
P.O. Box 10095, Lancaster, PA 17605

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 (as defined under Eligibility within the brochure) 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) non-related employees of the employer's eligible employees must be enrolled in the GemStar Dental and/or Vision 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.

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 Cards 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.

EMPLOYER INFORMATION

Name of Employer: _____ **Send Correspondence to:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone Number: (___) _____ **Fax: (___)** _____

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: _____

_____

Effective Date Requested:
_____ **(limited to 1st or 15th of the month)**

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

PLAN SELECTION

DENTAL APPLICATION AND PARTICIPATION AGREEMENT

❒ **Dental Gemstar PPO 1500**
❒ **Voluntary** ❒ **Employer Funded**

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 of which _____ are enrolled in this Plan.

CURRENT DENTAL PLAN

Is this group currently enrolled under another group dental program? ❒ Yes ❒ No
Are CPT 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 hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under Group Dental Policy GH-1112-38070-02 insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

Authorized Signature _____

Date _____ E-Mail _____

VISION APPLICATION (*not available in NJ, VT, WA*)

❒ **Vision Gemstar PPO 1500 (9752007)**
❒ **Voluntary** ❒ **Employer Funded**

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 of which _____ are enrolled in this Plan.

It is agreed that the Policy will become effective at rates to be determined by Us, provided the application is accepted by Us. The applicant declares that to the best of its knowledge and belief that statements and answers are complete and true.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Authorized Signature _____

Date _____ E-Mail _____

GHA-1157

PRODUCER'S STATEMENT – I hereby certify that all the information contained in this Employer Election Form 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 _____ SS#/TIN#_____ Appointed with Security Life? ❒ Yes ❒ No

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____ Signature _____

GemStar Group Enrollment Card: Return completed form to your employer

FOR COMPANY USE ONLY
Effective Date: _____/_____/_____
Plan Code: _____
Group # / Division _____
CPT: _____
SLIC

Employer Information (TO BE COMPLETED BY THE EMPLOYER)

Name and Address of Employer or Organization (if applicable)	Full-Time Hire Date
	Telephone Number

Employee Information (PLEASE PRINT CLEARLY)

Coverage Election: ☐ Dental Only ☐ Vision Only ☐ Dental & Vision **Note: Vision Plans not available in NJ, VT, WA**

I apply for coverage on: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family

Last Name	First Name	Initial	Birth Date M/D/Y / /
Address	Telephone Number		Sex: ❒ Male ❒ Female
City	State / Zip		Marital Status ❒ Married ❒ Single

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Spouse					/ /
Dependent					/ /
Dependent					/ /
Dependent					/ /

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

1. Does Spouse have a dental plan: Yes ☐ No ☐ With whom? _____
   If answer is "Yes", are dependents enrolled under spouses plan? Yes ☐ No ☐

Group Dental Coverage is provided under the Group Dental Insurance Policy GH-1112 issued to the Employers' Voluntary Benefit Insurance Trust insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

Group Vision Coverage is provided under the Group Vision Policy GH-1157 or under the Group Vision Policy GH-1154 issued to the Group Policyholder (policyholder may be a trustee group policyholder in some states) insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

By my signature below, I hereby apply for the coverage or coverage's selected above. I certify that 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.

California Law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

_____ _____
Employee Signature Date

IMPORTANT FRAUD NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STATE SPECIFIC NOTICES

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky - Any person who knowingly and with intent to defraud any insurer 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.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

Tennessee - 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.

Virginia - 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.