

Check Type of Plan:  Single  Single + One (1) Eligible Dependent  Single + Family  Vision  
 \$1,200 Annual Maximum  \$2,000 Annual Maximum

Last Name		M <input type="checkbox"/> F <input type="checkbox"/>		For Company Use Only	
Home Address		Mo. Day Yr. Birthdate		Effective Date	
City, State, Zip		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		Plan Code	
Telephone:		Sex M <input type="checkbox"/> F <input type="checkbox"/>		Sex M <input type="checkbox"/> F <input type="checkbox"/>	
List Below All Eligible Dependents to be Covered		Birthdate Mo. Day Yr.		First Name	
Last Name (if different)		Sex M <input type="checkbox"/> F <input type="checkbox"/>		Initial	
2. (Spouse)		Mo. Day Yr.		5.	
3. (Child)		Mo. Day Yr.		6.	
4.		Mo. Day Yr.		7.	

Does your spouse have a dental plan?  Yes  No With whom? \_\_\_\_\_ If answer is "Yes", are dependents enrolled under spouse's plan?  Yes  No  
 Do you claim a tax exemption for all eligible dependents listed above?  Yes  No If no, whom do you not claim? \_\_\_\_\_  
 All dependent children listed above over Age 18 are full-time students:  Yes  No If no, who is not? \_\_\_\_\_

By my signature below, I hereby apply for coverage under Group Dental Insurance Policy Form GH-1112 issued to the Voluntary Group Trust. I also certify I have read the applicable Fraud Notices located in the brochure.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 GHA-1112

Please mail completed form to:  
**Moro Insurance Group**  
 8825 S. Howell Avenue, #300  
 Oak Creek, WI 53154

**PLAN INFORMATION**

**Eligible Expenses:** Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To become an Eligible Expense, the dental services must be performed by: a licensed Physician performing dental services within the scope of his license; or a licensed dental hygienist acting under the supervision and direction of a Dentist.

**Expenses Incurred:** An Eligible Expense is considered incurred on the following dates: for full and partial dentures - on the date the final impression is taken; for fixed bridges, crowns, inlays and onlays - on the date the teeth are first prepared; for root canal therapy - on the date the pulp chamber is opened; for periodontal surgery - on the date surgery is performed; for all other services - on the date the service is performed.

**Expenses Not Covered:** No benefits will be paid for expenses incurred: for charges in excess of those considered reasonable and customary; for overdentures and associated procedures; for cosmetic procedures; for the replacement of full and partial dentures, bridges, inlays, onlays, or crowns that can be repaired or restored to normal function; for implants, and for the replacement of orthodontic retainer, the replacement of lost or stolen appliances, athletic mouthguards, precision or semi-precision attachments, denture duplication; for plaque control, the completion of claim form, acid etch, broken appointments, prescription or take-home fluoride, or for diagnostic photographs; for services not completed by end of the month in which coverage terminates, unless continuation of coverage has been requested by us; for procedures that are begun, but not completed; for those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge; 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 care or treatment of a condition for which you are entitled to or eligible for benefits under any Worker's Compensation Act or similar law; that are applied toward satisfaction of a Deductible, if any; 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 specifically included); prior to the date the Insured is covered under the Policy; for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD); for hospital services.

**Alternate Benefit:** If: (1) We determine that a less expensive alternate procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and (2) the alternative treatment will produce a professionally satisfactory result, then the maximum we will allow will be the charge for the less expensive treatment.

**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.

**GENERAL INFORMATION**

**ELIGIBILITY:** Individuals 18 and over plus their eligible dependents (spouse and unmarried children from birth to age 19; extended to age 23 if child is a full-time student). This is subject to state requirements

**DEDUCTIBLE AMOUNT:** The Deductible is shown in the Coverage Schedule. The Deductible is an amount of covered dental charges incurred by an insured person for which no benefits will be paid

**CALENDAR YEAR MAXIMUM:** The maximum amount payable for all Eligible Dental Expenses in any calendar year as shown in the Coverage Schedule. The Calendar Year Maximum will apply to each insured person.

**PRETREATMENT REVIEW:** If the Course of Treatment will exceed \$300, We will request prior review. We must be given the dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate, less expensive Course of Treatment if it will produce professionally satisfactory results. If You do not request a pretreatment review, We will pay for the least expensive method of treatment regardless of the method actually used.

**COORDINATION OF BENEFITS:** This Plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits. This helps keep the cost of the Plan reasonable.

**TERMINATION OF COVERAGE:** Coverage terminates on the earliest of the following dates: the last day of the month in which You cease to be eligible for coverage; the last day of the month in which Your dependent is no longer a dependent, as defined; 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 the date the policy ends.

**EFFECTIVE DATE:** Plan effective dates are always the First of the month. Enrollment cards received by Direct Benefits after the First of the month will become effective on the First of the following month. Incomplete enrollment cards or failure to submit the required initial premium amount may cause an initial delay in Issuance of insurance. Do not cancel any other Insurance or assume You are insured under the Plan until You receive written confirmation from Direct Benefits.

**VISION EXPENSES NOT COVERED**

- The cost of a lens in excess of a standard lens will not be covered. A standard lens is any lens which fits a frame with an eye size less than 61mm. Charges for replacement lenses will not be covered unless there is a change in prescription.
- The cost of a frame in excess of a standard frame will not be covered. A standard frame is any frame which has a retail value of \$65.00 or less. The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.

- In addition to the above, the following expenses are not covered:
  - any procedure, service or supply included as a covered medical expense under any group insurance plan, whether benefits are payable as to all or only part of such charges;
  - special procedures, such as orthoptics, vision training and subnormal vision aids;
  - plano or prescription sunglasses or other special purpose vision aids;
  - medical or surgical treatment of the eyes, including hospital expenses;
  - replacement of lost or broken lenses and/or frames;
  - duplicate glasses or lenses or frames; and
  - services or material not listed as an Eligible Expense.

**IMPORTANT FRAUD NOTICES**

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

**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.

**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.

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

**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 to and civil penalties.

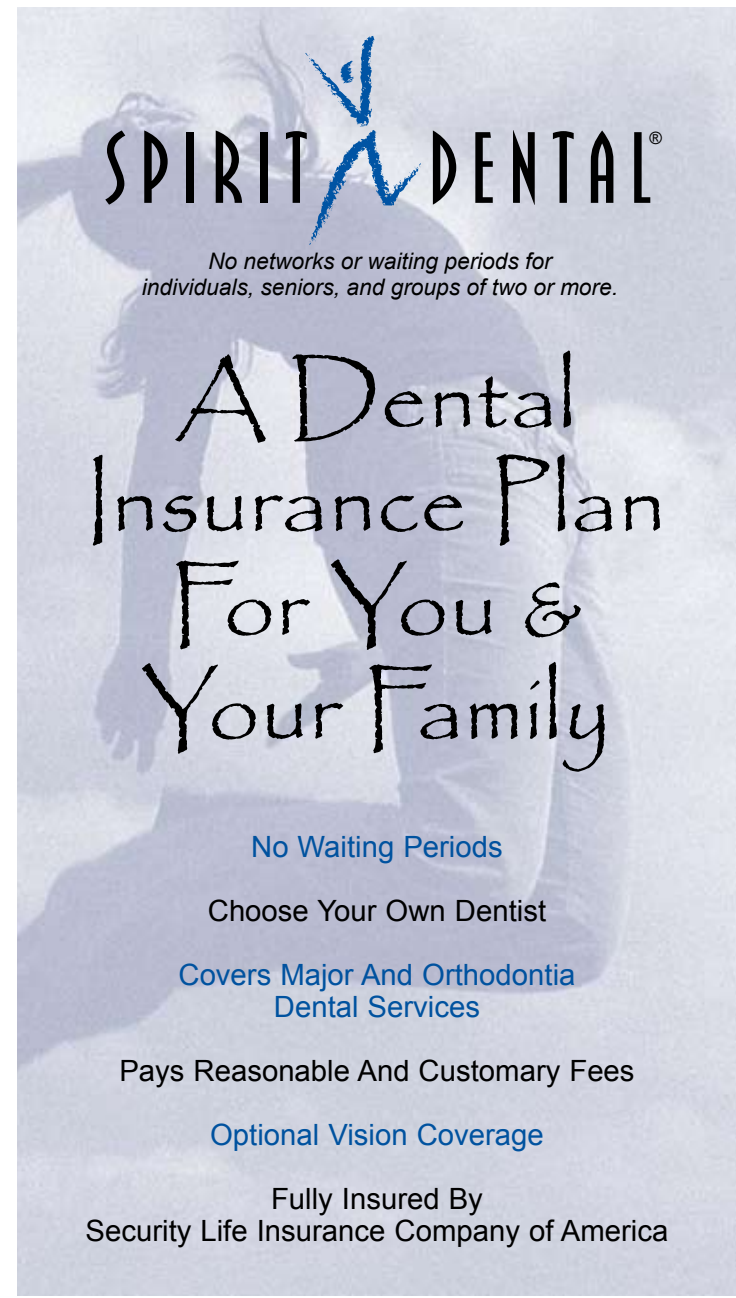
**Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**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.

**AGENT INFORMATION** (For agent use only)

Producer Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 SSN/TIN \_\_\_\_\_  
 EMail Address \_\_\_\_\_  
 Insurance License # \_\_\_\_\_  
 Agent Number (if applicable) \_\_\_\_\_  
 Are you currently appointed with Security Life Insurance Company?  
 YES  NO  
 License Attached?  YES  NO  
 PRODUCER NAME \_\_\_\_\_  
 PRODUCER SIGNATURE \_\_\_\_\_  
 DATE \_\_\_\_\_  
 GENERAL AGENT \_\_\_\_\_

Insured By:  
**Security Life**  
**INSURANCE COMPANY OF AMERICA**  
 10901 Red Circle Drive, Minnetonka, MN 55343-9137



**SPIRIT DENTAL**

No networks or waiting periods for individuals, seniors, and groups of two or more.

**A Dental Insurance Plan For You & Your Family**

No Waiting Periods

Choose Your Own Dentist

Covers Major And Orthodontia Dental Services

Pays Reasonable And Customary Fees

Optional Vision Coverage

Fully Insured By Security Life Insurance Company of America



**Plan Coordinator:** Moro Insurance Group  
 8825 S. Howell Avenue, #300  
 Oak Creek, WI 53154  
 414-766-9700 • 800-553-6676  
 www.morogroup.com



## A Dental Insurance Plan for You & Your Family

This Dental Insurance Plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures.

This Plan reimburses you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those covered expenses after the \*\$100 lifetime deductible has been satisfied. These percentages are:

100% for Preventive Services, 50% for Basic and 10% for Major and Ortho Services in the 1st year.

In the 2nd year of coverage, Basic Services increase to 65%, and the Major and Ortho Services increase to 25%.

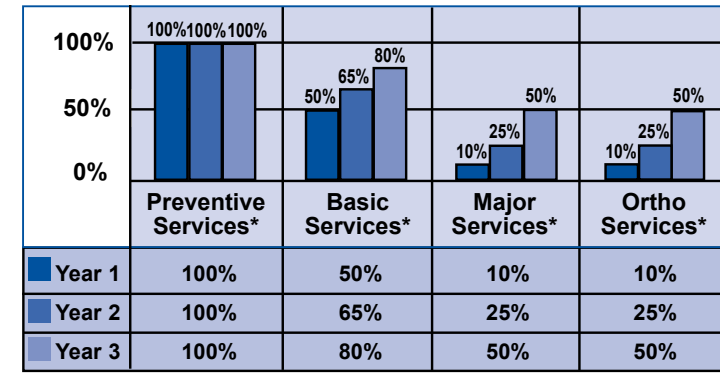
In the 3rd year, Basic Services increase to 80% and Major and Ortho Services increase to 50% of the R&C Rate.

Spirit Dental allows you to select your own dentist, and it is affordable for you and your family.

- \* \$100 Lifetime Deductible PER PERSON.
- \* \$1200 calendar year maximum benefit per person.
- \* \$2000 maximum benefit available at a 10% rate increase.

**REASONABLE AND CUSTOMARY** - means the usual, customary and regular charges for the area where such expenses are incurred.

**NOTICE:** 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 Insurance Contract. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Policy Form GH-1112-37740-1 issued to the Voluntary Group Trust.



### PREVENTIVE\*

- two exams per year
- two cleanings per year

### BASIC \*

- Space maintainers
- one series of bitewing x-rays per year
- Sealants (children to age 16)
- one topical fluoride per year to age 16

### MAJOR \*

- Simple extractions
- Implants (endosteal only), up to the allowance for the lowest cost covered traditional procedure
- One diagnostic xray, full or panoramic in any 3 year period
- Oral surgery
- Endodontic treatment
- Periodontic services
- Restoration services; inlays, onlays and crowns
- Prosthetic services; bridges and dentures
- Basic fillings

### ORTHODONTIA \*

- Orthodontic care for the proper alignment of teeth is provided only to dependent children who are under 19 when treatment is received
- Coverage is 10% 1st year, 25% 2nd year and 50% 3rd year with a \$1000 lifetime maximum per child

Rates effective 03/09 - 02/10

Dental premium rates illustrated are guaranteed for six months from effective date, and may increase on a semi-annual basis.			
Area	Applicant Only Under Age 65 / Over Age 65	Applicant + 1 Under Age 65 / Over Age 65	Applicant + Family Under Age 65 / Over Age 65
1	\$26.50 / \$28.43	\$58.40 / \$56.25	\$84.96 / \$79.88
2	\$29.05 / \$31.17	\$64.03 / \$61.67	\$93.15 / \$87.58
3	\$31.93 / \$34.25	\$70.36 / \$67.77	\$102.36 / \$96.24
4	\$35.12 / \$37.68	\$77.40 / \$74.54	\$112.60 / \$105.86
5	\$38.63 / \$41.44	\$85.14 / \$82.00	\$123.86 / \$116.45
6	\$42.46 / \$45.55	\$93.59 / \$90.13	\$136.14 / \$128.00
7	\$46.61 / \$50.01	\$102.73 / \$98.94	\$149.45 / \$140.51
8	\$51.40 / \$55.14	\$113.29 / \$109.10	\$164.81 / \$154.95

### AREA (STATE) DEFINITIONS

Alabama	(California cont.)	Idaho	Louisiana	Montana	North Dakota	South Dakota	(Virginia cont.)
350-355, 359	943-948	All Areas	707-711	590-591	580-581	All Areas	228-229, 240-244
All Other	956-958	Illinois	712	599	All Other	Tennessee	233-237
Alaska	949, 961	600-605	All Other	All Other	Ohio	373-374	All Other
995-996	959	606-608	Massachusetts	All Areas	All Areas	Washington	982-984
All Other	All Other	All Other	All Areas	1	1	990-992	3
Arizona	803, 808-810	Indiana	463-464	890-891	740-743	Texas	993
856-857, 864	473	All Other	488-489	894-895, 898	All Other	751-753	990-992
All Other	All Other	1	473	977	1	754	4
Arkansas	Delaware	2	488-489	Oregon	3	756-757, 776-777	All Other
All Areas	All Areas	1	All Other	4	2	All Other	5
California	Dist Columbia	2	Minnesota	New Mexico	1	977	West Virginia
900-905	All Areas	6	All Areas	881	2	All Areas	255-257
906-914	Georgia	4	Kansas	882	5	All Other	262-265
915-916	300-303	2	All Other	Mississippi	1	All Areas	All Other
917-918	All Other	1	1	390-392	2	Wisconsin	1
919-927, 930-934	Hawaii	6	1	All Other	2	All Areas	1
939	All Areas	3	1	Missouri	1	Wyoming	All Areas
				640-641, 644-649	2	All Areas	1
				All Other	1		
				All Other	1		



## Optional Spirit Vision Insurance Plan

Freedom to Choose Your Own Eye Care Provider  
Services Offered:  
Lifetime-Per Person Deductible of \$50.00 on Lenses and Frames

	Maximum Covered Expense
Examination.....	\$50.00 (once every calendar year with \$10 copay)
Frames (once every 24 months).....	\$65.00
Lenses (once every 12 months)	
Single.....	\$40.00
Bifocal.....	\$60.00
Trifocal.....	\$70.00
No line bifocal or progressive power	
OR Lenticular.....	\$100.00
Contact Lenses (in lieu of lenses and frames).....	\$100.00

	Monthly Premium	
	To age 65	Age 65 & over
Insured only	\$7.80	\$9.36
Insured & 1 (child or spouse)	\$14.90	\$17.88
Insured & 2 or more	\$19.97	\$23.96

Premiums are determined by area. To determine your monthly premium rate, refer to the Zip Code Area Chart and Dental Premium Chart. You may choose an optional \$2,000 Benefit plan for a 10% increase to the base rate.

Rate	=	_____
[ ] Optional \$2,000 benefit (rate x .10)	+	_____
Monthly Total	=	_____
[ ] Optional Vision	=	_____
Application Fee (\$10 if enrolled at www.spiritdental.com)	+	\$30.00
Total Remittance	=	\$ _____

Payment options include Visa/Mastercard or checking/savings account bankdraft.

Note: Visit any provider. Vision is available only as a rider to the Spirit Dental plan (not stand-alone). The vision rider is optional to purchase, but cannot be terminated separately from dental.

Do not cancel any other dental coverage you may have until you receive written confirmation from Security Life.



### PAYMENT OPTIONS

[ ] Monthly Bank If choosing to pay monthly Bank, you must complete and sign the Authorization Agreement form and submit it along with two (2) months premium, a \$30 enrollment fee and your completed Dental Application.

[ ] Monthly Credit Card If choosing to pay by credit card, you must complete and sign the Authorization Agreement form below.

### AUTHORIZATION AGREEMENT:

I hereby authorize Security Life Insurance Company of America to initiate entries to my banking or credit card account. This authorization shall remain in full force until company has received advance written notification from me to terminate.

Name of Financial Institution \_\_\_\_\_ Account Number: \_\_\_\_\_

[ ] Checking Account (include voided check) \_\_\_\_\_

or [ ] Savings Account (include deposit slip) \_\_\_\_\_ Account Number: \_\_\_\_\_

[ ] Visa [ ] Master Card Card # \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_