Secure DentalOne Application for Coverage (Connecticut)

Underwritten by Standard Security Life Insurance Company of New York

Group information: Name - Communicating for America; Location - Washington, DC

APPLICANT

Applicant Last Name________________________________

First Name____________________________M.I.________

Social Security number______________________________

Street Address_____________________________________

City________________________State____Zip________

Birthdate____/____/_____Sex........❏ Male ❏ Female

Marital Status.............................❏ Single ❏ Married

Telephone number(___)___-______________________

Email____

COVERAGE

Check Those That Apply (Note: If declining coverage(s), complete the section REFUSAL/WAIVER only)

Dental Insurance

❏ Member ❏ Spouse ❏ Children

Requested Effective Date__________/____/______

Plan Name Elected________________________________

DEPENDENT INFORMATION

Spouse's Name______________________________________

Birthdate____/____/________Sex ....❏ Male ❏ Female

Child's Name________________Sex ....❏ Male ❏ Female

Birthdate___/___/_____Student (over age 19)........❏ Yes ❏ No

Child's Name________________Sex ....❏ Male ❏ Female

Birthdate___/___/_____Student (over age 19)........❏ Yes ❏ No

Child's Name________________Sex ....❏ Male ❏ Female

Birthdate___/___/_____Student (over age 19)........❏ Yes ❏ No

Child's Name________________Sex ....❏ Male ❏ Female

Birthdate___/___/_____Student (over age 19)........❏ Yes ❏ No

Will you or any dependent have other dental insurance coverage?........................❏ Yes ❏ No

If yes, please list the name of the other insurance company and phone number:____________________

Replacement - Is this coverage intended to replace any other dental plan? ....❏ Yes ❏ No

REFUSAL/WAIVER

Complete only if you are declining coverage for yourself or any dependent.

I decline coverage for:

❏ Myself ❏ My spouse ❏ My children

Reason for refusal:_________________________________

ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the Standard Security Life Insurance Company of New York group plan offered by the Group. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. To the best of my knowledge and belief, all answers are true and complete.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Date_______________City and State___________________

Signature of Applicant______________________________

SSL ADEN-MBR APP CT 0606

NOTICE TO BUYER: THIS IS AN APPLICATION FOR DENTAL INSURANCE ONLY. READ YOUR CERTIFICATE CAREFULLY.

Note: This application is valid only for residents of Connecticut. To apply for Secure DentalOne in other states, see generic or state-specific applications.

Secure DentalOne Rate Calculation Chart (CT)

Underwritten by Standard Security Life Insurance Company of New York

Secure DentalOne Rate Chart

Rates	BasicOne NA	ClassicOne $750	PremierOne $1,250
Single	7.18	23.16	28.10
Single + 1	13.54	43.67	52.98
Single + 2	17.68	57.03	69.18
Single + 3	21.82	70.38	85.38
Single + 4	25.96	83.74	101.58
Single + 5	30.10	97.09	117.78
Single + 6 or more	34.24	110.44	133.98

ZIP CODE AND AREA RATE FACTOR CHART

State		Factor
Connecticut	*all other zips*	1.19
Connecticut	*068-069*	1.28

SDO Zip areas CT 7-07

CALCULATE YOUR COST

1. Based on the plan desired and people to be insured. Enter your monthly rate. $ _____
2. Locate your state and zip code prefix. Enter the factor. _____
3. Multiply the rate by the factor. x $ _____
4. Add the Optional OrthoCare Discount Program
   Individual + $ 5.00
   Individual + 1 or more + $ 8.00
5. Add the monthly administration fee. + $ 5.00

Subtotal $ _____

6. Multiply by number of months
   [___ (months) x $______ (subtotal) =] + $ _____
7. Add the **ONE-TIME** enrollment fee + $ 20.00

Total Due $

Make checks payable to: HPA, Inc.
Mail application to: HPA, Inc.,
P.O. Box 340869 Tampa, FL 33694-0869

Save time and postage when paying by credit card, fax your completed application toll free to: 1-888-FAX-HPA1 (329-4721)

PAYMENT METHOD

Select your payment method:

❑ Automatic bank draft ❑ Checking ❑ Savings

Payer name or Depositor if different________________

Relationship to applicant________________

Signature________________Date________

Name of financial institution________________

Routing #________________

Account #________________

Address of financial institution________________

City________________State______Zip______

Credit Card: ❑ VISA ❑ Mastercard ❑ Discover

Name on Account________________

Account #________________

Expiration________________

Verify account #________________

I hereby authorize the premiums and fees to be deducted from my bank account or credit card as indicated above and remitted to HPA, Inc. on a frequency basis as indicated above. I further authorize the bank or credit card to pay and charge to my account those payments that are drawn on my account by HPA, Inc. and I agree that the bank or credit card named shall be fully protected in honoring any such payments. The bank's rights or credit card's rights and treatment of each payment shall be the same if it were signed by me. If any such payment is dishonored, with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorization remains in effect until the bank or credit card is notified by me in writing. To terminate coverage I will also notify HPA, Inc. the administrator in writing. I further hereby enroll in the CA Association and understand participation is mandatory.

Applicant signature________________Date_____

AGENT USE ONLY

Are you currently appointed with Standard Security Life Insurance Company of New York? ❑ Yes ❑ No

Agent Name ________________

HPA # ________________

Address ________________

City ________________State _____Zip________

Phone ________________ Email ________________

GA Name ________________ # ________

MGA Name ________________ # ________