CONNECTICUT

A Dental Insurance Plan For You & Your Family

INDEMNITY AND DHA-PREMIER PPO

No Waiting Periods

Choose Your Own Dentist

Three Cleanings Per Year

Covers Major Dental Services

Optional Vision Coverage

Free Prescription Drug Card

Distributed by:

Plan Coordinator:

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

Fully Insured by Security Life Insurance Company of America

GH-1112-37740-1
Form S 11330 (Rev 02-11)

Indemnity – Choose Your Own Dentist

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 policy pays you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those covered expenses after the $50 lifetime deductible has been satisfied on Preventive Services and the $50 combined calendar year deductible has been satisfied on Basic and Major Services. These percentages are: 100% for Preventive Services, 70% for Basic and 50% for Major Services in the 1st year. In the 2nd year of coverage, Basic Services increase to 80%. In the 3rd year, Basic Services increase to 90%.

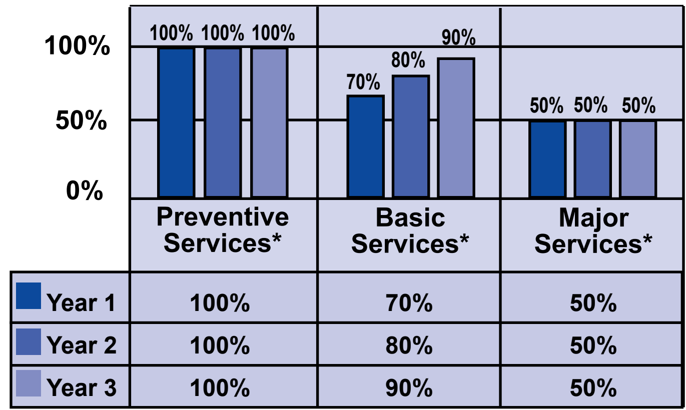
Spirit Dental allows you to select your own dentist, and it is affordable for you and your family.

* Deductibles are to a maximum of 3 Individual deductibles per family.
* $50 Preventive Lifetime deductible per person.
* $50 combined Basic/Major calendar year deductible per person to a maximum of 3 individual deductibles per family per calendar year.
* $1200 calendar year maximum benefit per person.
* $2000 calendar year maximum option for 10%.

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 Policy Form GH-1112-37740-1.

Covered Services



	Preventive Services*	Basic Services*	Major Services*
Year 1	100%	70%	50%
Year 2	100%	80%	50%
Year 3	100%	90%	50%

PREVENTIVE*
- -- two exams per calendar year
- -- three cleanings per calendar 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 x-ray, 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

Year 1 major maximum is $250, year 2 is $500, and year 3 and after has no separate major maximum.

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 peridontal surgery - on the date surgery is performed; for all other services - on the date the service is performed.

DENTAL EXPENSES NOT COVERED: 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 replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, 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; 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; 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 included within Coverage Schedule; prior to the date the Insured is covered under the Policy; for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD); for hospital services; for any unmarried child age 19 years of age and over unless he is dependent upon You for support, while a full-time student. A full-time student is one who is enrolled for 12 semester hours for credit in an accredited junior college, college or university. Any exception for a full-time student will end at age 23; 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.

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.

Insured By:

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

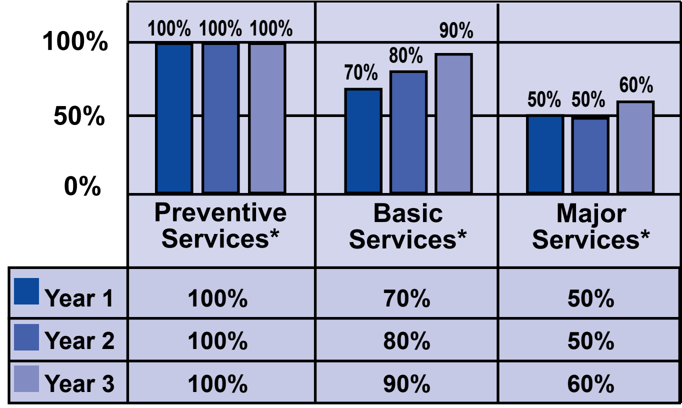
DHA-Premier PPO Network Dentists

Covered Services

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 policy pays you for covered dental expenses based on the DHA or Premier PPO fee schedule for those covered expenses after the $50 lifetime deductible has been satisfied on Preventive Services and the $50 combined calendar year deductible has been satisfied on Basic and Major Services. These percentages are: 100% for Preventive Services, 70% for Basic and 50% for Major in the 1st year. In the 2nd year of coverage, Basic Services increase to 80%. In the 3rd year, Basic Services increases to 90% and Major Services increase to 60%.

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



	Preventive Services*	Basic Services*	Major Services*
Year 1	100%	70%	50%
Year 2	100%	80%	50%
Year 3	100%	90%	60%

* Deductibles are to a maximum of 3 Individual deductibles per family.
* $50 Preventive Lifetime deductible per person.
* $50 combined Basic/Major calendar year deductible per person to a maximum of 3 individual deductibles per family per calendar year.
* $1200 calendar year maximum benefit per person.
* $2000 calendar year maximum option for 10%.

To look up DHA-Premier PPO providers, please visit www.premier-dental.com.

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PREVENTIVE*
-- two exams per calendar year
-- three cleanings per calendar 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 x-ray, full or panoramic in any 3 year period
-- Oral surgery
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-- Periodontic services
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-- Basic fillings

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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 peridontal surgery - on the date surgery is performed; for all other services - on the date the service is performed.

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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.

Dental Network:

DHA - PREMIER

www.premier-dental.com

Insured By:

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

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

Service	Maximum Covered Expense
Examination	$50.00

(once every calendar year with $10 copay)
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.

Service	Maximum Covered Expense
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

	Under 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

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:
  1. 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;
  2. special procedures, such as orthoptics, vision training and subnormal vision aids;
  3. plano or prescription sunglasses or other special purpose vision aids;
  4. medical or surgical treatment of the eyes, including hospital expenses;
  5. replacement of lost or broken lenses and/or frames;
  6. duplicate glasses or lenses or frames; and
  7. services or material not listed as an Eligible Expense.

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.*

Coverage for:

- Exams
- Frames
- Lenses
- Contact Lenses

For more information, call:

Direct Benefits, Inc. at 800-620-5010

S11035 (3-07)

Indemnity – Choose Your Own Dentist

Send completed form to: *Direct Benefits, Inc., 325 Cedar St., Suite 800, St. Paul, MN 55101*
phone 651-649-3503 • fax 651-649-3502 • info@directbenefits.com

Premium rates illustrated are guaranteed for initial twelve months and may change annually thereafter.

Area	Applicant Only Under Age 65 / Age 65 and over		Applicant + 1 Under Age 65 / Age 65 and over		Applicant + Family Under Age 65 / Age 65 and over	
5	45.29	48.57	94.72	100.45	136.40	144.31

Rates effective 02/01/11 - 01/01/12

Premiums are determined by area. To determine your monthly premium rate, refer to the Area/State charts on this page. 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)	=	___________
[ ] Optional Vision	=	___________
[ ] Optional Credit for Prior Time (CPT) (rate x .35)	=	___________
Monthly Total	=	___________
Application Fee ($20 if enrolled at www.spiritdental.com)		+ $35.00
Total Remittance	=	$__________

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

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 ______________________________

TAKEOVER CREDIT BENEFITS

If you were previously covered under a group dental plan you may be eligible for credit for the time you were covered under that plan. The length of time you were covered under your prior plan will be applied to the graded benefit features of this plan which means you will enter the plan at a higher level of benefit for coverage categories that grade up over time. To enjoy this feature you must provide an evidence of coverage letter from your prior carrier. This letter must include a termination date of the prior plan that is no more than 30 days prior to the date we receive your application for coverage under the Spirit Dental plan. Takeover benefits are available for a 35% rate increase to the base rate.

SPIRIT DENTAL CONNECTICUT AREA/STATE FACTORS

Connecticut

All area	5

DHA-Premier PPO Network Dentists

Send completed form to: *Direct Benefits, Inc., 325 Cedar St., Suite 800, St. Paul, MN 55101*
phone 651-649-3503 • fax 651-649-3502 • info@directbenefits.com

Premium rates illustrated are guaranteed for initial twelve months and may change annually thereafter.

Area	Applicant Only Under Age 65 / Age 65 and over		Applicant + 1 Under Age 65 / Age 65 and over		Applicant + Family Under Age 65 / Age 65 and over	
5	37.98	40.73	75.51	79.84	107.30	113.11

Rates effective 02/01/11 - 01/01/12

Premiums are determined by area. To determine your monthly premium rate, refer to the Area/State charts on this page. 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) = ___________
[ ] Optional Vision = ___________
[ ] Optional Credit for Prior Time
(CPT) (rate x .35) = ___________
Monthly Total = ___________
Application Fee + $35.00
($20 if enrolled at www.spiritdental.com)
Total Remittance = $__________

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

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 ______________________________

TAKEOVER CREDIT BENEFITS

If you were previously covered under a group dental plan you may be eligible for credit for the time you were covered under that plan. The length of time you were covered under your prior plan will be applied to the graded benefit features of this plan which means you will enter the plan at a higher level of benefit for coverage categories that grade up over time. To enjoy this feature you must provide an evidence of coverage letter from your prior carrier. This letter must include a termination date of the prior plan that is no more than 30 days prior to the date we receive your application for coverage under the Spirit Dental plan. Takeover benefits are available for a 35% rate increase to the base rate.

SPIRIT DENTAL CONNECTICUT AREA/STATE FACTORS

Connecticut

All area	5

Please send completed form to: **Direct Benefits, Inc.**
325 Cedar Street, Suite 800
Saint Paul, MN 55101
phone: 651.649.3503 • fax: 651-649-3502
info@directbenefits.com

DENTAL APPLICATION

Insured By Security Life Insurance Company of America - Minnetonka, Minnesota

		/ / Mo Day Yr	M [ ] F [ ]	
Email Address	Last Name First Initial	Birthdate	Sex	Effective Date

Home Address

Marital Status
[ ] Married [ ] Single

City, State, Zip Telephone:

Billing Address (if different than the above)

LIST DEPENDENTS TO BE COVERED (list spouse first) Last Name (if different) First Name Initial	Sex M F	Birthdate Mo. Day Yr	Last Name (if different) First Name Initial	Sex M F	Birthdate Mo. Day Yr
2. Spouse			5.		
3. Child			6.		
4.			7.		

Does 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, who is not? ______________________________
All dependent children listed above over Age 18 are full time students:
☐ Yes ☐ No If no, who is not? ______________________________
____

I am enrolling for coverage on:
[ ] Myself Only [ ] Myself + 1 [ ] Myself + Family

Coverage Elections:
[ ] $1,200 Annual Maximum [ ] Indemnity
[ ] $2,000 Annual Maximum [ ] DHA-Premier PPO
[ ] Credit for Prior Time (CPT) [ ] Vision Option

Fraud Notice - 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.

BY MY SIGNATURE, 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 ABOVE FRAUD NOTICE.

Applicant's Signature Agent Name (if applicable) Date
GHA-1112

PAYMENT OPTIONS – $35 enrollment fee ($20 if enrolled at www.spiritdental.com)

[ ] Monthly Bank If choosing to pay monthly Bank, you must complete and sign the Authorization Agreement form and submit it along with one months premium payable to Security Life Insurance Company of America/SLICA 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/Meritain Health to initiate debit 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. I agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, the bank or credit card company shall be under no liability whatsoever even though it might result in forfeiture of my insurance. I understand that I have the right to stop payment by notification to Security Life Insurance Company of America, my bank or my credit card company at least ten business days prior to the next scheduled payment.

Name of Financial Institution ______________________________

or [ ] Checking Account (include voided check) Account Number: ______________________
[ ] Savings Account (include deposit slip) Account Number: ______________________
[ ] Visa [ ] Master Card Card #______________________ Expiration Date_____/____/_____

Name: ______________________________

Signature: ______________________________ Date: ______________________

Policy: GH-1112-37740-1
Form: S-11330

FREE Prescription Drug Card

Spirit Dental and Vision is proud to offer you and your family/friends a **FREE DISCOUNT DRUG CARD**. Simply print the free card below and receive savings of up to 75 percent at over 50,000 pharmacies across the country (savings average around 30 percent). This card is especially helpful if you are uninsured or underinsured. However, even if you have insurance, you can still use this card to get a discount on non-covered drugs. All prescriptions processed through the program are completely **confidential** (no name required on card)!

This program also includes discounts on Eyeglasses, Hearing, Nutritional Supplements, Diabetic Supplies, Dental, and more. You can print as many cards as you need. Please feel free to forward this **FREE** Prescription Drug Card to your friends and family. **This card is pre-activated and can be used immediately!**

Rx Prescription Drug Card

NAME: ______________________________

RxMBR ID: Customer's Ten (10) Digit Phone Number
OR Initials & Last 4 Digits of Phone Number

RxGRP: NWDBENEDV RxBIN: 610709 RxPCN: 7777

PROGRAM: UNA RX CARD – UNITED NETWORKS OF AMERICA

NOTE: This card is being provided to you at NO COST. There are no forms to fill out. Simply take this card into a participating pharmacy (see back) with your Rx to qualify for discounts on medications. You also have access to other value added programs listed on back. Each family member must have his/her own card. This card has been pre-activated for immediate use! To obtain information and to print additional cards, visit www.spiritdental.com.

Compliments of:
SPIRIT DENTAL AND VISION

Powered by:
United Networks of America
RESTAT

Customer Service (CSR)
877.321.6755

Pharmacy Helpline
800.248.1062

THIS PROGRAM IS NOT INSURANCE
THIS PROGRAM IS A POINT OF SALE DISCOUNT PLAN

ADDITIONAL SAVINGS

25DOLLAREYEGLASSES.com	$25.00 Prescription Eyeglasses www.25dollareyeglasses.com
ProSmile	Teeth Whitening-Save up to 70% www.prosmileusa.com
DIABETIC SAVINGS plan	Diabetic Supplies-Save up to 50% www.diabeticsavingsplan.com
QualSight	Lasik Surgery-Save 40-50% Call 1-888-733-6695
USHEARINGPLAN.COM	Hearing Aids-Save up to 50% www.ushearingplan.com

PARTICIPATING PHARMACIES:

* ***This program is not insurance and is not affiliated with Security Life Insurance Company.***

NEW APPLICATION CHECKLIST

To expedite processing please confirm that the following is submitted.

- ☐ Completed Application
- ☐ Signed Application
- ☐ Premium payment (payable to Security Life Insurance Company of America/SLICA) along with the $35 one-time application fee ($20 if enrolled at www.spiritdental.com)
- ☐ Completed and Signed Agent Information section when applicable
- ☐ Certificate of creditable coverage if requesting Takeover Benefits

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

*All Spirit One-Life Dental plans come with our **10-day Customer Satisfaction Guarantee**.*

You have 10 days after your plan becomes effective to cancel your plan if you are not satisfied for any reason. Any premium paid (minus the enrollment fee) will be fully refunded provided no covered services have been rendered.

If services have been provided, you may still cancel your policy, however, the premium paid will not be eligible for reimbursement.