



# Secure DentalOne Application for Coverage (Generic)

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: \_\_\_\_\_

## 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. I declare 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 0606

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

**NOTE: This application is not valid in ID, TX and UT. See the appropriate state-specific forms to apply for Secure DentalOne in those states.**

## Fraud Warning Statements

Residents of states listed below are subject to specific fraud warnings as outlined. Residents of all other states are subject to fraud warning found within application at left, or within state-specific application as applicable.

**Residents of Arkansas**—WARNING: 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. (SSL ADEN-MBR APP AR 0606)

**Residents of Indiana**—WARNING: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony. (SSL ADEN-MBR APP IN 0606)

**Residents of Kentucky**—WARNING: Any person who knowingly and with intent to defraud any insurance company 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. (SSL ADEN-MBR APP KY 0606)

**Residents of Louisiana**—WARNING: 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. (SSL ADEN-MBR APP LA 0606)

**Residents of Maine**—WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. (SSL ADEN-MBR APP 0606 ME)

**Residents of Ohio**—WARNING: 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. (SSL ADEN-MBR APP OH 0606)

**Residents of 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. (SSL ADEN-MBR APP PA 0606)



## Secure DentalOne Rate Calculation Chart (Generic)

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### ZIP CODE AND AREA RATE FACTOR CHART

Alabama	0.81	Missouri	0.81
Alaska	1.60	630-634, 640-641	0.91
Arizona	0.91	Montana*	
850-853	1.00	Nebraska	0.81
Arkansas	0.81	Nevada	1.09
California	1.09	893-898	1.19
900-904	1.28	New Hampshire*	
905-916, 926-931	1.19	New Jersey*	
940-944	1.28	New Mexico	0.91
945-951	1.19	New York*	
Colorado	1.00	North Carolina	0.91
800-804	1.09	275-277	1.00
808-809	1.09	282	1.09
Connecticut*		North Dakota	0.81
Delaware	1.19	Ohio	0.81
Dist of Columbia	1.19	430-432, 434-436	0.91
Florida	1.00	439-445, 450-452	0.91
330, 332-334, 340	1.09	456	0.91
331	1.19	Oklahoma	0.81
Georgia*		730-731, 740-741	0.91
Hawaii	1.09	Oregon	1.00
Illinois	0.81	970-975	1.09
600-608	1.09	Pennsylvania	0.91
610-619	0.91	190-191	1.09
Indiana	0.81	189, 192-194	1.09
460-466, 469, 473	0.91	Rhode Island	1.00
Iowa	0.91	South Carolina	0.91
Kansas*		South Dakota	0.81
Kentucky	0.81	Tennessee	0.81
Louisiana (call for rates)		370-372, 380-384	0.91
Maine (call for rates)		Vermont*	
Maryland*		Virginia*	
Massachusetts*		Washington*	
Michigan	0.91	West Virginia	0.81
480-485	1.00	Wisconsin	0.91
Minnesota*		532-534, 537	1.00
Mississippi*		Wyoming	0.81

SDO Zip areas 1-07

\*See current state approval chart or call HPA at 800-277-3323 x3 for the current area factors.

### Secure DentalOne Rate Chart

	BasicOne	ClassicOne	PremierOne
<b>Rates</b>	<b>NA</b>	<b>\$750</b>	<b>\$1,250</b>
Single	3.59	13.62	16.53
Single + 1	6.77	25.67	31.15
Single + 2	8.84	33.53	40.69
Single + 3	10.91	41.38	50.22
Single + 4	12.98	49.23	59.75
Single + 5	15.05	57.09	69.28
Single + 6 or more	17.12	64.94	78.81

### CALCULATE YOUR COST

- Based on the plan desired and people to be insured. Enter your monthly rate. \$ \_\_\_\_\_
  - Locate your state and zip code prefix. Enter the factor. \_\_\_\_\_
  - Multiply the rate by the factor. x \$ \_\_\_\_\_
  - Add the Optional OrthoCare Discount Program  
*Individual* + \$ 5.00  
*Individual + 1 or more* + \$ 8.00
  - Add the monthly administration fee. + \$ 5.00
- Subtotal** \$ \_\_\_\_\_
- Multiply by number of months  
 [ \_\_\_ (months) x \$ \_\_\_\_\_ (subtotal) = ] + \$ \_\_\_\_\_
  - Add the **ONE-TIME** enrollment fee + \$ 20.00

**Total Due**

\$

### 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 \_\_\_\_\_ # \_\_\_\_\_

### 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 \_\_\_\_\_

**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)**