



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

A Dental Insurance Plan For Seniors & Their Families

No Waiting Periods

Choose Your Own Dentist

Covers Major Dental Services

Pays Reasonable And Customary Fees

Fully Insured By Security Life Insurance Company of America

Distributed by:



Plan Coordinator:

*Direct Benefits, Inc.
570 Asbury Street, Suite 206
Saint Paul, MN 55104
651-649-3503 • 1-800-620-5010*

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 Services in the First year. In the Second year of coverage, Preventive is 100%, Basic increase to 65% and Major to 25%. In the Third year, Preventive is 100%, Basic increases to 80% and Major 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.
- * \$1000 calendar year maximum benefit per person.
- * \$1500 maximum benefit available at a 15% 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 issued to the Voluntary Group Trust.

PLAN INFORMATION

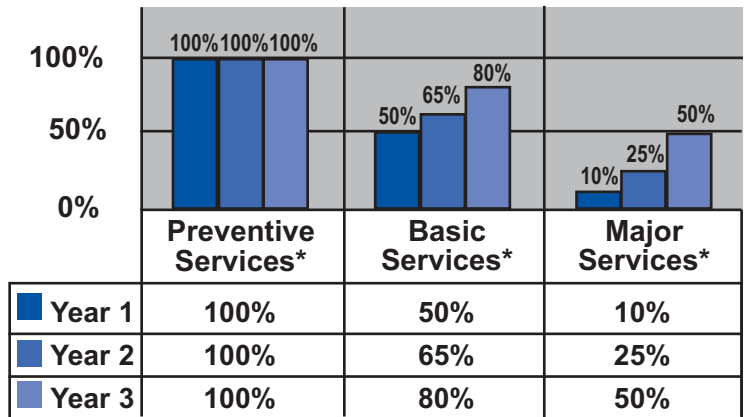
ELIGIBLE EXPENSES: Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To become an Eligible Expense, the dental services must be performed by: a licensed Physician performing dental services within the scope of his license; or a licensed dental hygienist acting 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 (a) the replacement of orthodontic retainer, (b) the replacement of lost or stolen appliances, (c) athletic mouthguards, (d) precision or semi-precision attachments, (e) denture duplication, or for (f) sealants; for oral hygiene instructions, and for (a) plaque control, (b) the completion of claim form, (c) acid etch, (d) broken appointments, (e) prescription or take-home fluoride, or for (f) 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.

Covered Services



PREVENTIVE*

- two exams per year
- two cleanings per year
- one topical fluoride per year to age 16

BASIC *

- Simple extractions
- Space maintainers
- one series of bitewing x-rays per year

MAJOR *

- 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

GENERAL INFORMATION

ELIGIBILITY: Individuals ages 65 and older 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

policy: GH-1112-37740-1
(Rev 02/06)
Form: S-10678

Mail completed form to: Direct Benefits, Inc., 570 Asbury Street, Suite 206, St. Paul, MN 55104

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 \$1,500 Benefit plan for a 15% increase to the base rate. Rate = _____ + _____ [] Optional \$1,500 benefit (rate x .15) = _____ Monthly Total = _____ Application Fee + \$20.00 Total Remittance = \$ _____ Payment options include Monthly Bank, Quarterly or Semi-annual Direct Bill. Direct Bill options charge a \$2 billing fee per billing.		Premium rates illustrated are guaranteed for six months from effective date, and may increase on a semi-annual basis.			
		Area	Application Only	Applicant + 1	Applicant + Family
1	\$23.48	\$46.46	\$65.98		
2	\$25.74	\$50.93	\$72.34		
3	\$28.29	\$55.97	\$79.49		
4	\$31.12	\$61.57	\$87.44		
5	\$34.23	\$67.72	\$96.18		
6	\$37.63	\$74.44	\$105.72		
7	\$41.30	\$81.72	\$116.06		
8	\$45.55	\$90.11	\$127.98		

AREA (STATE) DEFINITIONS											
Alabama 350-355, 359 All Other	3 1	Colorado 803, 808-810 All Other	4 1	Kansas 660-662 All Other	2 1	Montana 590-591 599	1 2	Ohio All Areas	1	Utah All Areas	1
Alaska 995-996 All Other	8 6	Delaware All Areas Dist Columbia	2 2	Kentucky All Areas Louisiana	1 1	Nebraska All Areas Nevada	1 1	Oklahoma All Other	3	Oregon All Other	1
Arizona 856-857, 864 All Other	2 1	Georgia 300-303 All Other	6 2	Kentucky 707-711 All Other	2 1	Nevada 890-891 894-895, 898	2 6	Oklahoma 740-743	2	Oregon 977 978	3 5
Arkansas All Areas	1	Hawaii All Areas	3	Michigan 480-483, 490-491 488-489	2 3	New Mexico 881 882	2 5	Pennsylvania 170-178, 182-187 190-192	2 3	Washington 982-984 990-992	4 3
California 900-905 906-914 915-916 917-918	7 6 8 4	Idaho All Areas Illinois	1 1 2	Minnesota 553-558, 564, 566 All Other	2 1	North Carolina All Other	1	South Carolina All Areas	1	West Virginia 255-257	5 4
919-927, 930-934 939 943-948 956-958 949, 961 959 All Other	6 6 4 3 6 3 4 5	Indiana 606-608 All Other All Areas	3 1 1	Mississippi 390-392 All Other	3 2	Missouri 640-641, 644-649 All Other	2 1	Tennessee 286 287-289 All Other	3 2 1	Texas 373-374 All Other	2 3
		606-608 All Other All Areas	3 1 1			North Dakota 580-581 All Other	2 1	Tennessee 373-374 All Other	2	Wisconsin All Areas	3 1

Rates effective 02/06-01/07 (Rev 02/06)

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 lose 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 Christopher D. Gardner			
Street Address 6331 White Tail Dr. #61			
City West Linn	State OR	Zip 97068	Phone 503-693-1186
SSN/TIN 56-2424146		EMail Address cgardner@insurancestoreonline.com	
Insurance License # 606756		Agent Number (if applicable)	

Are you currently appointed with Security Life Insurance Company? [x] YES [] NO

License Attached? [] YES [x] NO

PRODUCER NAME Christopher D. Gardner

PRODUCER SIGNATURE _____ DATE _____

GENERAL AGENT The Insurance Store



Please mail completed form to: **Direct Benefits, Inc.**
570 Asbury Street, Suite 206
St. Paul, MN 55104 651-649-3503

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

				/ / Mo Day Yr	M [] F []	For Company Use Only	
Social Security No.	Last Name	First	Initial	Birthdate	Sex	Effective Date	
Home Address				Marital Status [] Married [] Single		Plan Code	
City, State, Zip			Telephone:				
Billing Address (if different than the above)						Waiver	CPT

LIST DEPENDENTS TO BE COVERED (list spouse first)			Sex	Birthdate				Sex	Birthdate
Last Name (if different)	First Name	Initial	M F	Mo. Day Yr	Last Name (if different)	First Name	Initial	M F	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 applying for coverage on:
 Myself Only
 Myself + 1
 Myself + Family

 \$1,000 Annual Maximum
 \$1,500 Annual Maximum

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim, or any application containing any false, incomplete, or misleading information is guilty of a crime. I hereby apply for coverage under group policy series GH-1112 and its state-specific versions and riders.
 BY MY SIGNATURE, I HEREBY APPLY FOR COVERAGE UNDER GROUP DENTAL INSURANCE POLICY FORM GH-1112 ISSUED TO THE VOLUNTARY GROUP TRUST.

Applicant's Signature _____ Date _____
 GHA-1112

PAYMENT OPTIONS

Monthly Bank If choosing to pay monthly Bank, you must complete and sign the Bank Authorization form and submit it along with two (2) months premium, a \$20 enrollment fee and your completed Dental Application.

BANK AUTHORIZATION:

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

Name of Financial Institution _____

Checking Account (include voided check) Account Number: _____
 or
 Saving Account (include deposit slip) Account Number: _____

Name: _____

Signature: _____ Date: _____

Quarterly Direct Bill If choosing to pay quarterly, submit three (3) months premium, and a \$20 enrollment fee along with your completed Dental Application. There is a \$2 per bill fee for direct bill.
 Semi-Annual Direct Bill If choosing to pay semi-annually, submit six (6) months premium, and a \$20 enrollment fee along with your completed Dental Application. There is a \$2 per bill fee for direct bill.

Outlook Vision Services – Clearly the Best Vision Benefits Plan for You

Your dental plan includes a vision discount plan through Outlook Vision Services. The vision plan includes discounts on the purchase of eyeglasses, contact lenses, sunglasses and other prescription eyewear when provided by Outlook Vision Services providers. Eye exam discounts* and discounts on corrective surgery (Lasik) are available at select locations. Outlook Vision Services is available for you and everyone covered on your dental plan.

Easy To Use.

- 1) Find a provider – Call Outlook @ 800-342-7188 or visit www.outlookvision.com
- 2) Choose the frames, lenses or contacts you like
- 3) Present your card with the Outlook logo to a preferred provider
- 4) Pay the discounted price

This Vision Discount Plan is not Insurance.

* Exam discounts may not be available at all locations. CA and WA providers do not offer exam discounts.

- Discounts 10% to 50% on eyewear
- Over 10,000 preferred optical centers nationwide
- Discounts on eye exams at select locations
- Covers spouse and children
- Elective contact lenses
- Choose from entire eyeglass frame inventory
- Choose lenses (Single, Bifocal, Trifocal, Progressive, Contacts, etc.)
- Purchase multiple pairs
- Use as often as you like
- Never file a claim

SPIRIT DENTAL

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



OUTLOOK
VISION SERVICES