

"LIFE-SMILE" DENTAL PLAN ENROLLMENT

Applicant full name: _____
 Address: _____
 City: _____ State _____ Zip: _____
 Age: _____ Birthdate _____ Male Female Phone: _____
 Social Security #: _____
 Spouse's Social Security #: _____
 Billing Address: _____

COMPLETE THIS ITEM TO INSURE YOUR SPOUSE AND/OR CHILDREN

Full Name (First, MI, Last)	Birthdate	Age	M	F
SPOUSE	/ /			
CHILD 1	/ /			
CHILD 2	/ /			
CHILD 3	/ /			

By my signature below, I hereby apply for dental coverage under master policy series **Myself Only** **Myself and Spouse** **Myself and Children** **Myself and Family**
1. Does Spouse have a dental plan? Yes No With whom?
2. Are dependents enrolled under spouse's plan?
3. Do you claim a tax exemption for all eligible dependents listed above? Yes No
4. All dependent children listed above over Age 18 are full time students? Yes No
 I understand that the insurance applied for shall become effective on the date specified by Allianz Life Insurance Company of North America (the "Company") only if this application is approved by the Company and the first premium is paid during the lifetime of the insured. I represent that to the best of my knowledge and belief all statements and answers recorded on this application are true and complete and they will be a basis of issuance of insurance by the Company.

Signature of Applicant _____ Date _____

Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Allianz Life Insurance Company of North America, Minneapolis, MN

MAKE CHECK PAYABLE TO:

Health Plan Administrators, Inc. • PO Box 17812, Tampa, FL 33682

Plan Selection	Premium Calculations
<input type="checkbox"/> \$1,000 MAX <input type="checkbox"/> \$1,500 MAX	Enter Premium Here \$ _____
<input type="checkbox"/> Orthodontia	Multiply by Area Factor X _____
Billing Method	Subtotal \$ _____
<input type="checkbox"/> Direct Monthly Bill	Annual Enrollment Fee+\$ 10.00
<input type="checkbox"/> MasterCard, Visa, DiscoverCard	Monthly Admin. Fee +\$ 5.00
<input type="checkbox"/> Automatic Bank Draft	Total Amount Due \$ _____

List Bill Available, call HPA for details and list bill forms

FOR CREDIT CARD PAYMENT, please complete the following:

I authorize Health Plan Administrators, Inc. to bill my VISA/MC/DISCOVER account for the monthly premium. VISA MC DISCOVER

List digits of Account # _____ Exp. Date _____
 Cardholders' Signature _____ Date _____

If **Automatic Check Withdrawal** is selected, your monthly Allianz Life premium will be automatically withdrawn from your checking account. Please complete the Authorization Form below:

REQUEST FOR AUTOMATIC CHECK WITHDRAWAL

To: _____
 (Print full name of Bank or Branch where account is maintained.)

Street Address: _____
 City & State: _____

I request that you pay and charge my account, debits drawn on my account by Health Plan Administrators, Inc. to its own order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advance written notice to me and to Health Plan Administrators, Inc. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____

Include One Voided Check With Application

FOR AGENTS USE ONLY	Agent Name Kevin J. Hoyle - Carolina Health Benefits, Inc.
	Address 11310 Wagonford Lane Tel # 704-588-5090
	City Charlotte State NC Zip 28273
	SS # 56-1982060 HPA Code # _____
	G.A. Name _____ Phone # _____

PLAN INFORMATION THE COMPETITOR LIFE-SMILE PLAN

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

EXPENSES INCURRED: An Eligible Expense is considered incurred on the following date:

- For full and partial dentures – the date the final impression is taken.
- For fixed bridges, crowns, inlays and onlays – the date the teeth are first prepared.
- For root canal therapy – the date the pulp chamber is opened.
- For periodontal surgery – the date surgery is performed.
- For all other services – the date the service is performed.

COORDINATION OF BENEFITS

If any insured is also covered under another plan(s), the benefit under this plan will be coordinated with benefits payable under all other plans. This coordination will apply if the sum of the benefits payable under this plan in the absence of coordination and the benefits payable under all other plans would exceed such Eligible Expenses. When Coordination of Benefit applies, benefits payable under this plan will be reduced so that the sum of those benefits payable under other plans do not exceed the total Eligible Expenses.

EXPENSES NOT COVERED

No benefits will be paid for expenses incurred:

- For any portion of a charge for any service in excess of the Reasonable and Customary charge as determined for the area where services are rendered.
- For any procedure not listed as a Scheduled Benefit.
- 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 lost or stolen appliances; (b) the replacement of orthodontic retainers; (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 a claim form; (c) acid etch; (d) broken appointments; (e) prescription or take-home fluoride; or (f) diagnostic photographs.
- For services and procedures that are begun, but not completed by the end of the month in which coverage terminates.
- 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 charges in connection with an orthodontic service or procedure, if this optional benefit is not selected.
- 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 the insured is entitled to or eligible for benefits under any Workers' Compensation Act or similar law.
- That are applied toward satisfaction of a Deductible.

TERMINATION

An insured's coverage shall terminate on the earliest of the following dates:

- The date the Master Policy terminates.
- Any payment due date, subject to a Grace Period of 31 days, if that payment toward the cost of his insurance has not been made.
- The first day of the month coinciding with or next following the date he ceases to be a member of the organization.
- The date the person attains age 65.
- The first day of the month coinciding with or next following the date the insured dependent is no longer a dependent as defined in the Policy.

This brochure contains a brief description of the benefits payable. Complete details may be found in Master Policy No. 20557, Group Policy Form No. PDENT-004.5

The "Competitor Life - Smile" Dental Plan



"Life-Smile" Dental

AN INDIVIDUAL DENTAL PLAN FOR YOU AND YOUR FAMILY

- ◆ Freedom to choose any Dentist
- ◆ Pays Benefits Based on the Reasonable and Customary Fees
- ◆ Automatic Acceptance
- ◆ Personal Portability
- ◆ Initial Benefits for Preventive Care
- ◆ Optional Orthodontia Coverage
- ◆ Choose \$1000 or \$1500 Maximum Per Insured Person Per Year
- ◆ Direct Bill, List Bill, Payroll Deduction, Automatic Bank Draft, MasterCard, Visa or Discover Card

Underwritten By: Allianz Life Insurance Company of North America
 Minneapolis, Minnesota

Rated A+ (Superior) by A.M. Best Reports
 Administered By: Health Plan Administrators, Inc.
 Rockford, Illinois

THE COMPETITOR LIFE-SMILE DENTAL PLAN

Choose Maximum Benefit Options of \$1,000 or \$1,500

Per Insured, Per Calendar Year

Benefit Schedule Per Insured Person

Care	Deductible	Benefit	Beginning
Preventive	\$35 Lifetime	80%	On Day One
Basic Care	\$75 Per Year	50%	After 6 Months
Major Care			After 15 Months
Orthodontia*	\$75 Per Year	50%	After 24 Months
*(Optional Benefit)			

ELIGIBILITY

All members of the U.S. Benefits Association age 64 and under are eligible for coverage. Spouses age 64 and under and children from birth to 19 years (23 years, if full-time student) will be considered dependents of the members and are ineligible for coverage except as dependents.

EFFECTIVE DATE

Coverage will be effective on the date that his/her application has been received by the Administrator.

HOW THIS PLAN WORKS

Allianz Life will pay benefits for eligible expenses incurred while the person is insured under the Policy, up to a maximum per **Calendar Year of \$1,000 or \$1,500**, as elected.

BENEFITS:

- A. Preventive Procedures** include Preventive and Diagnostic Services
- \$35 Lifetime Deductible per person
 - Benefits paid at 80% of Reasonable and Customary Charges*
 - No Waiting Period
- B. Basic Procedures** include Restorative, Endodontics, Periodontics, Oral Surgery and Adjunctive Services
- \$75 Calendar Year Deductible per person (1)
 - Benefits paid at 50% of Reasonable and Customary Charges*
 - 6 Month Waiting Period
- C. Major Procedures** include Restorative – Major, Prosthetics – Removable and Fixed Bridges
- \$75 Calendar Year Deductible per person (1)
 - Benefits paid at 50% of Reasonable and Customary Charges*
 - 15 Month Waiting Period
- D. Orthodontia** (optional benefit)
- \$75 Calendar Year Deductible per person
 - Benefits paid at 50% of Reasonable and Customary Charges*
 - 24 Month Waiting Period
 - Maximum benefit \$500 per insured child per calendar year and a lifetime maximum benefit of \$1,000.

- (1) The Deductible for Basic and Major Procedures is a combined \$75 per Calendar Year.

* Reasonable and Customary Means:

- a) the provider's usual charge for the service or procedure
- b) the customary charge made for the same service in the area by other providers; and
- c) the regular charge for a service or procedure in the area where rendered.

COVERED EXPENSES

Deductibles, coinsurance and benefit maximums are per Covered Person

Preventive Services Include:

• routine oral examinations of mouth and teeth, 2 per calendar year; • prophylaxis (cleaning, scaling and polishing teeth), 2 per calendar year; • topical fluoride, 1 per calendar year to age 19; • diagnostic x-rays, full or panoramic 1 in any 3 year period; or • bitewing x-rays, 2 per calendar year.

Basic Services Include:

• simple extraction of one or more teeth; • fillings (restorations) using amalgam, silicate, acrylic, resin (anterior teeth only) and composite filling materials (restorations of the mesiolingual, distolingual, mesiobuccal and distobuccal surfaces will be considered single surface restorations); or • antibiotic injections administered by Dentist; • oral surgery, including post-operative care for: a) removal of one or more teeth; including impacted teeth; b) extraction of tooth root; c) alveolotomy, alveoplasty, and frenectomy; d) excision of periocoronal gingiva, excostosis, or hyperplastic tissue, and excisions of oral tissue for biopsy; e) reimplantation or transplantation of a natural tooth; f) excision of a tumor or cyst and incision and drainage of an abscess or cyst; and g) general anesthesia and analgesic, including intravenous sedation, for oral surgery; • endodontic treatment of diseases of the tooth, pulp, root and related tissue, as follows: a) root canal therapy (not covered, if pulp chamber was opened before covered); b) pulpotomy; c) apicoectomy; and d) retrograde fillings. • periodontic services, limited to: a) prophylaxis following surgery, 2 per calendar year; b) root scaling and root planning, once per quadrant of mouth in any 6 months period; c) occlusal adjustment, performed with covered surgery; d) gingivectomy, gingival curettage and mucogingival; e) osseous surgery including flap entry and closure; f) pedicle or free soft tissue grafts; and g) appliances (night guards), one in any 5 year period (splints – other than provisional splints) are not covered.

Major Services Included:

• pin retention of fillings; • space maintainers to preserve space between teeth caused by premature loss of primary tooth (baby tooth). This does not include use for orthodontic treatment. • study models, one in 3 year period; • crown buffed for non-vital teeth; • recementing inlays, onlays and crowns; • recementing bridges; • repairs to full or partial dentures or bridges, one in any 2 year period and not more than 20% of cost of replacement. Repairs within 1 year of placement is not covered; • restoration services, limited to: a) gold or porcelain inlays, onlays, and crowns, only for the tooth with extensive caries or fracture and is unable to be restored with an amalgam, silicate, acrylic, resin (anterior teeth only), or composite filling material. Crowns for the purpose of periodontal splinting are not covered. Gold or porcelain inlay, onlay, or crown when tooth was prepared before Insured was covered under the Policy is not covered. b) replacement of an existing inlay, onlay or crown, only after at least five years from restoration initially placed or last replaced. However, this limitation will not apply if replacement of an existing inlay, onlay or crown is made necessary by the extraction of one or more functioning natural teeth while the Insured is covered under the Policy. c) stainless steel crowns; d) post and core. • prosthetic services, limited to: a) initial placement of full or partial dentures or fixed bridgework (including acid etch metal bridges), only if the denture or bridgework includes replacement of a natural tooth extracted or lost while the Insured is covered under the Policy. This limitation will not apply after the Insured is covered under the Policy for 36 months. b) replacement of full or partial dentures or fixed bridgework that cannot be made serviceable, only after at least five years from the date denture or bridgework was initially placed or last replaced. Duplicate prosthetic appliance or replacement of any lost, missing or stolen prosthetic appliance is not covered. c) addition of one or more teeth to an existing partial denture, only if to replace one or more natural teeth extracted or lost while the Insured is covered under the Policy. This limitation will not apply after the Insured is covered under the Policy for 36 months. d) relining or rebasing of existing removable full or partial dentures, only after at least one year from the date the denture was placed and only once in and 2 year period. (Any prosthetic appliance or modification of any prosthetic appliance for which the impression was made before the Insured was covered under the Policy is not covered.)

Orthodontia Services (optional), for Insureds under 19 years of age: Charges not to exceed the contracted Maximum Benefit Amount shown in the Coverage Schedule at 50% of the Reasonable and Customary charge for procedures associated with orthodontic services.

RATES, ZIP CODE AND AREA FACTORS

State	Zip Code	Area Factor	State	Zip Code	Area Factor
Alaska	All	1.30	Minnesota	550, 553	.90
Arizona	850, 852-853	.95		551, 554	.95
	Rest of State	.90		Rest of State	.80
Arkansas	All	.80	Mississippi	390-392	.80
California	959-961	1.10		Rest of State	.75
	952-958	1.15	Missouri	633	.80
	905-912 917-918,			630-631, 640-641	.85
	940-942	1.25		Rest of State	.75
	900-904, 913-916,		Montana	All	.85
	943-951	1.30		Rest of State	.85
	Rest of State	1.20	Nebraska	681, 686-693	.80
	806, 808-810	.95		Rest of State	.75
	800-805	1.00	New Hampshire	All	.95
	Rest of State	.90		080-083	1.00
Colorado	060-062, 068-069	1.10	New Jersey	076-079, 085-088	1.05
	Rest of State	1.15		070, 089	1.15
Connecticut	199	.90		071-073	1.20
	197	.95		Rest of State	1.10
	198	1.00	New Mexico	870-872, 875	.90
				Rest of State	.85
Dist of Columbia	All	1.05	Nevada	889, 894-895, 897	.95
Florida	323-327, 336, 338-339	.85		891	1.00
	335, 340-341, 344-345	.95		Rest of State	.90
	334	1.00	N. Carolina	275-277	.85
	330, 333	1.10		Rest of State	.80
	331-332	1.15	*N. Dakota	All	.75
	Rest of State	.90	Ohio	430-432, 434-439,	
Georgia	308-309, 311-314,			442-447, 452-456, 458	.85
	318-319	.80		440-441	.90
	301-302, 399	.90		Rest of State	.80
	300, 303	.95	Oklahoma	730-731, 740-741	.85
	Rest of State	.75		Rest of State	.80
Hawaii	All	1.00	*Oregon	970-972	1.00
Idaho	All	.85		Rest of State	.95
Illinois	607	.90	Pennsylvania	150-163, 166, 168	
	604-605	.95		170-171, 173-180,	
	600-603, 606	1.00		182-188, 195	.90
	Rest of State	.80		164-165, 181, 189,	
Indiana	469, 476-477, 479	.80		193-194, 196	.95
	460-466	.85		190-192	1.00
	Rest of State	.75		Rest of State	.85
Iowa	503, 509, 524, 527-528	.80	Rhode Island	All	1.00
	Rest of State	.75	*S. Carolina	All	.80
Kansas	664-666, 670-671, 674	.80	S. Dakota	All	.75
	660-662, 672	.85	Tennessee	382-383	.75
	Rest of State	.75		370-372, 381	.85
Kentucky	405	.80		Rest of State	.80
	410	.85	Texas	750-751, 760-762, 777	.90
	Rest of State	.75		752-753, 773-776	.95
Louisiana	700-701, 708, 711	.85		770-772	1.00
	Rest of State	.80		Rest of State	.85
*Maryland	207-212	1.00	Utah	All	.90
	214	.95	Virginia	230-232, 238	.85
	Rest of State	.90		233-237	.90
Massachusetts	010-011, 014-015	.95		220-223	1.00
	016, 025-027	1.00		Rest of State	.80
	018-020, 023-024	1.05	Washington	986	1.05
	017, 021-022	1.10		980-981, 983-984	1.20
	Rest of State	.90		Rest of State	1.00
Michigan	498-499	.85	*W. Virginia	All	.75
	484, 489	.95	Wisconsin	537, 540, 542-543, 549	.85
	480-483, 485	1.05		530-532, 534	.90
	Rest of State	.90		Rest of State	.80
			Wyoming	All	.80

MONTHLY PREMIUM RATES

ALL STATES	1,000 Max	1,500 Max
Applicant	\$22.66	\$24.04
Applicant & Spouse	45.32	48.07
Applicant & Child(ren)	41.23	42.76
Applicant & Family	63.89	66.80
Applicant & Child	42.86	44.40
(with ortho)		
Applicant & Family	65.53	68.43
(with ortho)		

MONTHLY PREMIUM RATES

MINNESOTA	1,000 Max	1,500 Max
Applicant	\$20.22	\$21.45
Applicant & Spouse	40.44	42.89
Applicant & Child(ren)	36.79	38.16
Applicant & Family	57.01	59.61
Applicant & Child	38.24	39.62
(with ortho)		
Applicant & Family	58.47	61.06
(with ortho)		

*Rates must be multiplied by the appropriate area factor based on the insureds resident. The rates in this brochure will not be changed unless they are changed for all insureds in your classification.

MONTHLY PREMIUM RATES

NORTH CAROLINA	1,000 Max	1,500 Max
Applicant	\$21.90	\$23.24
Applicant & Spouse	43.81	46.47
Applicant & Child(ren)	39.86	41.33
Applicant & Family	61.76	64.57
Applicant & Child	41.43	42.92
(with ortho)		
Applicant & Family	63.35	66.15
(with ortho)		

*This plan is not yet available in these states. Call HPA for current approval status.