Carolina Health Benefits, Inc.
13000-F York Road, PMB 167
Charlotte, NC 28278
(704) 588-5090
Fax 588-7971
Email: Khoyle@chbi.com

What to do now.

1. The brochure and other printed materials are on the attached pages. To access them click on the pointer (<>) below or press Ctrl + Page Down.

If you want to proceed with this policy

2. Click on "file" and then "Print".
3. Fill out the printed application and any other pertinent sections in ink.
4. You and your spouse if applicable, sign in all requested locations.
5. Make out a check payable to the insurance carrier or as noted on the brochure.
6. Send to the address above.

SENIOR CHOICE DENTAL

An Insurance Plan For Seniors

MAXIMUM BENEFIT	$1,000.00 Per Insured Person Per Calendar Year	
DEDUCTIBLE AMOUNT *(Per Insured Person)*	**BENEFITS PAYABLE**	
	FIRST 12 MONTHS	**THEREAFTER**
$50.00 Calendar Year	85% Preventive[w]	85% Preventive
$50.00 Calendar Year	50% Basic[x] No Special No Major	50% Basic 50% Special[y]* 50% Major[z]*

*Special and Major Dental Services limited to maximum benefits of $500 per Calendar Year per insured person.

CLASS A BENEFITS
PREVENTIVE DENTAL SERVICES

[w]1-Month Waiting Period

- EXAMS
- CLEANINGS
- FLUORIDE *(Children to age 16)*

CLASS B BENEFITS
BASIC DENTAL SERVICES

[x]6-Month Waiting Period

- X-RAYS
- FILLINGS
- EXTRACTIONS *(Simple)*

CLASS C BENEFITS
SPECIAL DENTAL SERVICES

[y]15-Month Waiting Period

- ORAL SURGERY
  (Surgical Extractions & Impactions)
- ENDODONTICS
- PERIODONTICS

CLASS D BENEFITS
MAJOR DENTAL SERVICES

[z]18-Month Waiting Period

- CROWNS
- BRIDGES
- DENTURES

Reasonable and Customary Fees are charges that do not exceed the general level of charges being made by other providers of dental services in the State where the charge is incurred.

Insured By:

Security Life Insurance Company of America

10901 Red Circle Drive, Minnetonka, MN 55343-9137

CLAIMS: P.O. BOX 3506, HOPKINS, MN 55343-9506

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.

Form #S10272 1/99

SENIOR CHOICE DENTAL

An Insurance Plan For Seniors

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 a $50.00 annual deductible, this Plan will reimburse you 85% of the R&C rate for Preventive Dental Services.

After a $50.00 annual deductible, this Plan will reimburse you 50% of the R&C rate for Basic, Special and Major Dental Services.

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

SCHEDULE OF MONTHLY PREMIUMS
Effective 1/1/99

Area	APPLICANT ONLY	APPLICANT +SPOUSE	APPLICANT +CHILD(REN)	APPLICANT +FAMILY
I	$19.65	$38.30	$40.20	$54.20
II	21.75	42.50	44.55	60.10
III	24.45	47.90	50.20	67.75
IV	26.50	53.00	54.55	73.70
V	30.45	59.90	62.80	84.90

Product not available in all States. Contact **CAL/GROUP®** regarding current product approval in your State.

AREA (STATE) DEFINITIONS

- I = AR, IA, ID, KY, MS, NE, NC, ND, SC, WV, WI, WY
- II = GA, HI, IN, KS, LA, MN, MO, MT, NM, OK, TN, UT
- III = AZ, CO, DE, IL, OH, OR, MD, PA
- IV = DC, FL, MI, NV, TX, VA
- V = AK, CA, WA

QUESTIONS???

Contact Your Agent

SENIOR CHOICE DENTAL PLAN Enrollment Card

SCD | **FOR COMPANY USE ONLY**

SOCIAL SECURITY NUMBER | LAST NAME | FIRST | INITIAL | BIRTHDATE (MONTH DAY YEAR) | SEX ☐ M ☐ F | EFFECTIVE DATE

HOME ADDRESS | MARITAL STATUS ☐ Married ☐ Single ☐ Widowed ☐ Divorced | PLAN CODE

CITY, STATE & ZIP CODE | TELEPHONE ( ) | WAIVER | CPT

BILLING ADDRESS *(if other than home address)* | I AM APPLYING FOR COVERAGE ON ☐ Myself ☐ Myself and My Eligible Dependents | GROUP NO. | DIVISION NO.

CITY, STATE & ZIP CODE | TELEPHONE *(other)* ( )

LIST BELOW ALL DEPENDENTS TO BE COVERED

Last Name *(if different)*	First Name	Initial	SEX M F	BIRTHDATE MO. DAY YEAR	Last Name *(if different)*	First Name	Initial	SEX M F	BIRTHDATE MO. DAY YEAR
2. SPOUSE					5.				
3. CHILD					6.				
4.					7.				

Are any proposed insureds covered under another dental plan? ☐ YES ☐ NO

Will that other dental plan be terminated upon issuance of this dental plan? ☐ YES ☐ NO

All dependent children listed, over Age 18, are full-time students: ☐ YES ☐ NO

If "NO," who isn't?

Security Life Insurance Company of America MINNETONKA, MINNESOTA

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. I hereby apply for coverage under Policy Form GH-1112 issued to the Voluntary Group Trust.

APPLICANT'S SIGNATURE ______ DATE ______

Form #S10272

THREE WAYS TO PAY

☐ **Monthly Auto-Pay Plan:**

If choosing to pay monthly, fill out the Monthly Auto-Pay Authorization Agreement. Submit two (2) months premium plus a $25 enrollment fee. Make check payable to SLICA.

	MONTHLY PREMIUM		TOTAL PAID
Applicant	$_______	x 2 =	$_______
One-time Enrollment Fee			$ 25.00
TOTAL REMITTANCE			$_______

AUTHORIZATION AGREEMENT FOR MONTHLY PRE-AUTHORIZED PAYMENTS (PAC)

I hereby authorize Security Life Insurance Company of America, hereinafter called "COMPANY," to initiate debit entries to my Checking/Savings account (indicated below) at the financial institution (named below), hereinafter called "FINANCIAL INSTITUTION," and to debit the same to such account.

FINANCIAL INSTITUTION ______________________

☐ Checking Account *(include voided check)*
☐ Savings Account *(include deposit slip or copy of account statement)*

This authorization is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

Name ______________________ Date ______________

Signature ______________________

Account Number ______________________

ATTACH VOIDED CHECK OR OTHER DOCUMENTATION WITH THIS AGREEMENT.

☐ **Quarterly Direct Bill:**

If choosing to pay quarterly, submit three (3) months premium plus a $25 enrollment fee. Make check payable to SLICA.

	MONTHLY PREMIUM		TOTAL PAID
Applicant	$_______	x 3 =	$_______
One-time Enrollment Fee			$ 25.00
TOTAL REMITTANCE			$_______

☐ **Semi-Annual Direct Bill:**

If choosing to pay semi-annually, submit six (6) months premium plus a $25 enrollment fee. Make check payable to SLICA.

	MONTHLY PREMIUM		TOTAL PAID
Applicant	$_______	x 6 =	$_______
One-time Enrollment Fee			$ 25.00
TOTAL REMITTANCE			$_______

Producer Name Kevin J. Hoyle

Address 13000-F York Road, PMB 167

City/State/Zip Charlotte, NC 28278

Telephone [ ] 704 - 588-5090

Taxpayer ID or Soc. Sec. No. 5-1982060

Insurance License No. ______________ JALIC/NSM AGENT NO. ______

Insurance License Attached: ☐ YES ☒ NO

Are you currently appointed with Security Life? ☒ YES ☐ NO

Producer Signature On File (Kevin Hoyle)

NSM Rep. Name ______________ OFFICE & REP. NO. ______

SEND WITH PREMIUM & APPROPRIATE FEES TO YOUR NORTH STAR MARKETING OFFICE.

Please Call (800) 886-6762 For Office Nearest You.

Form #S10272 1/99 NSM-SCD

PLAN INFORMATION

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 services 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 ● 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 orthodontic services — on the date the appliance or bands are inserted or on the date a one-step orthodontic procedure 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 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 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 TMJ; ● 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.

GENERAL INFORMATION

ELIGIBILITY: Individuals who are 60 years of age and older, plus their eligible dependents (spouse and unmarried children from birth to age 19; extended to age 23 if the child is a full-time student).

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 require 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 CAL/GROUP 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 CAL/GROUP.

Plan Coordinator:

CAL/GROUP.
DENTAFITS, INC.
PALM SPRINGS, CA
(760) 416-9262

SENIOR DENTAL CHOICE

An Insurance Plan For Seniors

CHOOSE YOUR OWN DENTIST

COVERS MAJOR DENTAL SERVICES

PAYS REASONABLE AND CUSTOMARY FEES

FULLY INSURED BY SECURITY LIFE INSURANCE COMPANY OF AMERICA

Distributed By:

North Star Marketing Corporation
National Marketing

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