



Secure DentalOne Application for Coverage (Connecticut)

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: _____

Replacement - Is this coverage intended to replace any other dental plan? Yes No

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. To the best of my knowledge and belief, 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 CT 0606

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

Note: This application is valid only for residents of Connecticut. To apply for Secure DentalOne in other states, see generic or state-specific applications.

Secure DentalOne Rate Calculation Chart (CT)

Underwritten by Standard Security Life Insurance Company of New York

Secure DentalOne Rate Chart

	BasicOne	ClassicOne	PremierOne
Rates	NA	\$750	\$1,250
Single	7.54	24.32	29.50
Single + 1	14.22	45.87	55.64
Single + 2	18.56	59.87	72.63
Single + 3	22.91	73.90	89.65
Single + 4	27.26	87.93	106.67
Single + 5	31.61	101.96	123.69
Single + 6 or more	35.95	115.96	140.67

ZIP CODE AND AREA RATE FACTOR CHART

State	Factor
Connecticut all other zips	1.19
Connecticut 068-069	1.28

SDO Zip areas CT 1-08

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** \$

Make checks payable to: HPA, Inc

Mail application to: Insurance Services of America
 1757 E. Baseline Rd. Ste #126 Gilbert AZ 85233

Save time and postage when paying by credit card, fax your completed application to:
1-480-821-9297

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 _____

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 _____ # _____