

**MEMBER APPLICANT**

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Telephone Number (\_\_\_\_) \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex  Male  Female  
 Marital Status...  Single  Married  
 Email \_\_\_\_\_

**COVERAGE**

Requested effective date \_\_\_\_/\_\_\_\_/\_\_\_\_

**DEPENDENT INFORMATION**

Plan Name Elected \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Date of Birth \_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_  
 SSN # \_\_\_\_\_ Occupation \_\_\_\_\_  
 Child's Name \_\_\_\_\_  
 Sex  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Child's Name \_\_\_\_\_  
 Sex  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Child's Name \_\_\_\_\_  
 Sex  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Child's Name \_\_\_\_\_  
 Sex  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

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: \_\_\_\_\_

**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 represent that the information provided is true and complete to the best of my knowledge and belief.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Signature of Member Applicant \_\_\_\_\_

**FRAUD WARNING STATEMENTS**

The following states require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state as indicated below. If your state is not listed read the last statement marked "All Other States."  
**Residents of Arkansas**- 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 crime and may be subject to fines and or confinement in prison.  
**Residents of 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.  
**Residents of District of Columbia**- 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.  
**Residents of Kentucky**- 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.  
**Residents of Louisiana**- 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.  
**Residents of Maine**- 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.  
**NOTICE TO BUYER: THIS IS AN APPLICATION FOR DENTAL INSURANCE ONLY. READ YOUR CERTIFICATE CAREFULLY.**  
**Residents of 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.  
**Residents of 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.  
**Residents of Oklahoma**-Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.  
**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.  
**Residents of 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.  
**Residents of Virginia**-Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may have violated state law.  
**Residents of West Virginia**- 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.  
**All Other States**-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.

**Agent Use Only:** Are you currently appointed with Standard Security Life Insurance Company of New York?  Yes  No

Agent Name **DRS Insurance** IHC # \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Agent Signature \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

GA Name **Black, Gould & Associates** GA# **59180000**

MGA Name \_\_\_\_\_ MGA # \_\_\_\_\_

## Secure DentalOne: Premium and Payment Method

### Premium Amount

Monthly premium: \_\_\_\_\_

Enrollment fee: + \$20.00

Initial premium: = \_\_\_\_\_

### Payment Method

**Automatic bank draft:**    Checking    Savings

Payer name or Depositor if different \_\_\_\_\_ Relationship to applicant \_\_\_\_\_

Name of financial institution \_\_\_\_\_

Routing # \_\_\_\_\_ Account # \_\_\_\_\_

Street or PO Box of financial institution \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Credit Card:**    Visa    MasterCard    Discover

Name on Account \_\_\_\_\_

Account # \_\_\_\_\_ Expiration \_\_\_\_\_

I hereby authorize the premiums and fees to be deducted from my bank account or credit card as indicated above and remitted to IHC Health Solutions on a frequency basis as indicated above. I further authorize the bank or credit card to pay and charge my account those payments that are drawn on my account by IHC Health Solutions 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 IHC Health Solutions (the administrator) in writing. I further hereby enroll in Communicating for America, Inc., the association to whom the master policy is issued, and understand participation is mandatory.

**A \$25 service fee will be assessed for each dishonored payment. If necessary, I agree to pay this fee in addition to the amount of the payment due.**

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Make checks payable to: IHC Health Solutions  
Mail application to: IHC Health Solutions  
P.O. Box 15250 Loves Park, IL 61132-5250  
If paying by credit card, you may fax your application to: 888-329-4721

### Secure DentalOne ZIP Code and Area Rate Factor Chart

Alabama	0.81	Nevada	1.09
Alaska	1.60	893-898	1.19
Arizona	0.81	New Hampshire	1.09
850-851	0.91	New Jersey	1.09
852-853	1.00	070, 074-076, 078	1.19
Arkansas	0.81	079, 088-089	1.19
California	1.28	New Mexico	0.81
945-951	1.40	New York	0.91
Colorado	1.00	100-102	1.60
800-804	1.09	103-114	1.19
808-809	1.09	115-119	1.09
Connecticut	1.19	120-129	1.00
068-069	1.28	North Carolina	0.91
Delaware	1.19	275-277	1.00
Dist of Columbia	1.09	282	1.09
Florida	0.91	North Dakota	0.81
330, 332-334, 340	1.00	Ohio	0.81
331	1.09	Oklahoma	0.81
Georgia	0.81	Oregon	1.09
300-303, 311	1.00	970-975	1.19
Hawaii	1.09	Pennsylvania	0.81
Idaho	0.81	190-191	1.09
837	1.00	189, 192-194	1.00
Illinois	0.81	Rhode Island	1.00
600-608	1.00	South Carolina	0.91
Indiana	0.81	South Dakota	0.81
460-466, 469, 473	0.91	Tennessee	0.81
Iowa	0.91	370-372, 380-384	0.91
Kansas	0.81	Texas	0.81
Kentucky	0.81	750-753, 760, 761	0.91
Louisiana	0.81	770, 772-777, 786	0.91
Maine	1.00	787, 789	0.91
Massachusetts	1.09	Utah	1.00
017-019	1.19	Virginia	0.81
021-022	1.28	201	1.09
Michigan	0.91	220-223	1.00
480-485	1.00	233-237	0.91
Minnesota	0.91	980-981	1.28
554	1.09	982-986	1.19
550-553, 555	1.00	West Virginia	0.81
Mississippi	0.81	Wisconsin	0.91
Missouri	0.81	532-534, 537	1.00
630-634, 640-641	0.91	Wyoming	0.81
Nebraska	0.81		

### Secure DentalOne Rate Calculation Chart (Generic)

Underwritten by Standard Security Life Insurance Company of New York

Type of Coverage	BasicOne**	ClassicOne	PremierOne
Single	\$8.96	\$28.89	\$35.05
Single + 1	\$16.57	\$53.45	\$64.84
Single + 2	\$21.95	\$70.79	\$85.86
Single + 3	\$27.32	\$88.12	\$106.89
Single + 4	\$32.69	\$105.46	\$127.92
Single + 5	\$38.07	\$122.79	\$148.95
Single + 6 or more	\$43.44	\$140.13	\$169.97

\*\*BasicOne plan not available in Idaho or North Carolina.

### Calculate Your Cost

1. Enter your monthly rate based on the plan desired and people to be insured. \$ \_\_\_\_\_
2. Locate your state and ZIP code prefix. Enter the factor. X \_\_\_\_\_
3. Multiply the rate by the factor. = \$ \_\_\_\_\_
4. If age 65 or older, multiply by 1.25. X 1.25 = \$ \_\_\_\_\_
4. Add the monthly administration fee. + \$ 5.00
5. If elected, add optional OrthoCare\* (\$5.00 for an individual or \$8.00 for individual + 1 or more) + \$ \_\_\_\_\_
6. Multiply the subtotal by number of months. Subtotal \$ \_\_\_\_\_  
\_\_\_\_\_ (months) x \$ \_\_\_\_\_ (subtotal) = + \$ \_\_\_\_\_
7. Add the **ONE-TIME** enrollment fee + \$ 20.00

**Total Due**

\$ \_\_\_\_\_



\*The optional OrthoCare Discount Program is only available in the states of AZ, CA, CO, GA, KY, MA, MN, MS, OH, PA, RI, TN, VA and WI.