Security Life Insurance Company of America
10901 Red Circle Drive
Minnetonka, Minnesota 55343
800.233.0307

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

PrimeStar Individual Insurance Application

General Information

Last Name	First Name	Middle Initial

Address	Date of Birth (MM/DD/YYYY)

City	State	Zip	Marital Status ☐ Married ☐ Single

Telephone Number	Gender ☐ Male ☐ Female

Do you have any dental or vision insurance currently in force? ☐ Yes ☐ No
Is the insurance applied for intended to replace any existing insurance with this or any other company? ☐ Yes ☐ No
If yes, provide type of policy, number, and name of company:
If replacement is involved, have you received a replacement form (in states where required by law)? ☐ Yes ☐ No

Coverage Selection: ☐ Applicant Only ☐ Applicant + One ☐ Applicant + Family
List Dependents Below

Last Name	First Name	Initial	Sex M/F	Age	Date of Birth

1 Dental Plan Selection	☐ **Essential** *(NOT available in AK, ID, MA, NC, NJ, NY, SD, VT, WA)*	☐ **Advantage** *(NOT available in AK, CT, ID, IL, MA, MO, NC, NJ, NY, VT, WA)*	☐ **Advantage Plus** *(NOT available in CT, ID, IL, MA, MO, NJ, NY, SD, VT, WA)*	☐ **Complete** *(NOT available in ID, MA, NJ, NY, SD, VT, WA)*
2 Maximum Benefit Amount Selection	Comes with $500	☐ $1,000 ☐ $2,000	☐ $1,000 ☐ $2,000	☐ $1,000 ☐ $2,000

Choose one. A higher Maximum Benefit Amount will increase your premium amount.

3 Optional Vision Coverage ☐ Yes ☐ No *Optional vision coverage is available at an additional cost. Not available in MD, NY, SD, WA.*

Important Information

If you choose paper billings a fee of $6 will apply (not applicable for CO, IN, PA).
Effective date: The effective date is the first of the month following the day in which the application is received in the Service Center Office.
Identification Card and Policy: Upon receipt of your completed application you will be issued a copy of your policy and Identification Card(s). Do not cancel any other dental coverage you may have until you receive written confirmation from Security Life. Please allow 3-4 weeks for processing.

Important Notices (for all states not listed with state specific notices below)

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.

The following states require applicants to read and acknowledge the statement for your state below:

AL, MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AK, CO, LA, NJ, OH, OK, TN, VA, WV: Any person who knowingly intends to defraud an insurance company, submits an application or files a statement of claim containing any false, incomplete, or misleading information, commits the crime of fraud, and may be subject to criminal prosecution and civil penalties. In CO, and TN, additional penalties may include imprisonment, fines, or denial of insurance benefits. In CO, an insurer or insurance agent who knowingly provides false, incomplete, or misleading information to a 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.

DC: 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, the insurer may deny benefits if false information materially related or a claim was provided.

VT: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

KS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

KY, NM, PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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. In PA and NM, this activity subjects such a person to criminal and civil penalties.

OR, TX: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement may be guilty of fraud.

Please read and check box below to receive your policy electronically

☐ ***I consent to receiving my Policy, Outline of Coverage where applicable, and any other plan information electronically and I will electronically affirm or provide my signature below of my consent to do so. I understand I need internet access and that I can withdraw my consent at any time per the notification instructions below, I understand I can receive any of the documents in paper form if I choose. My email address is:*** _____

Applicant Signature

By signing below, the applicant acknowledges the above statements and understands or agrees to the following:

All statements and answers given in this application are true and complete to the best of my knowledge:

- **I may return my policy within the right-to-cancel period as described in my policy;**
- **I acknowledge receipt of the Outline of Coverage (in states where required by law);**
- **I understand the policy I am applying for provides dental and vision benefits only and is not a Medicare supplement;**
- **I acknowledge that the agent of record, if applicable, is my insurance agent for purposes of the Security Life Privacy Policy; and**
- **I understand that it is my responsibility to give notice to Security Life of changes in my e-mail address or any information above, as well as my status and my family's status that effect coverage, such as marriage, births, or death of someone covered under the policy. I will provide notice via fax 717.481.7175 or in writing to Security Life: P.O. Box 83149, Lancaster, PA 17608**

Applicant Signature _____ **Date** _____

Submit Application

Must submit with PrimeStar Payment Authorization Form & Replacement Notice (if applicable)

ONLINE	**MAIL**	**FAX**
SecurityLife.com	Security Life Insurance Company of America P.O. Box 83149 | Lancaster, PA 17608	717.481.7175

For Agent use only (if applicable)

Agent Name		Phone #	
Street Address	City	State	Zip
Email	SS#/TIN#/AAN#		
Appointed with Security Life? ☐ Yes ☐ No	Signature		
For Company use only	**Effective Date:**	**Plan Code:**	

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PrimeStar Payment Authorization Form

Applicant's Full Name:

Monthly Premium (from Rate Sheet):

Method of Payment (select one)

CHECKING ACCOUNT (ACH)

☐ Monthly Bank Account Debit
Submit 2 months of premium and a voided check

☐ Quarterly Bank Account Debit
Submit 3 months of premium and a voided check

CREDIT CARD

☐ Monthly Credit Card

Please select your card type below and provide your credit card account information:

☐ Visa ☐ MasterCard ☐ Discover

_____
Credit Card Number

_____ _____
Expiration Date CVC
(on back of card)

PAPER BILL

☐ Quarterly (3 months) Paper Bill
Submit 3 months of premium

☐ Semi-Annual (6 months) Paper Bill
Submit 6 months of premium

Paper billing begins on your policy effective date and we will provide you with a quarterly or semi-annual invoice of charges due for the insurance policy.

A $6 fee per bill will be applied on all future bills. (Not applicable to CO, IN, PA.)

Authorization Agreement

I authorize Security Life Insurance Company of America to initiate electronic debit entries to my account chosen above for payment of my insurance premium. My account will be debited by the third business day of the month in which premium is due. I understand I will receive a notice if the amount changes. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of the US law. (Applies only to ACH and Credit Card options.)

I understand that in order to make changes to this authorization (such as a change in bank account, method of payment, or termination of payment) I need to give Security Life written notification at least 10 days prior to the next scheduled payment. I understand that the insurance plan may be cancelled by Security Life if any payment is dishonored by my bank for any reason. In the case of an NSF, I am liable for any fees my bank may charge me and may also be responsible for an NSF fee of up to $25 which may be automatically debited for each NSF.

Your Signature _____ Date _____

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IF THIS IS A REPLACEMENT
leave the top half of this form with the Applicant and send the signed bottom half of this form with the Application

NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing dental insurance and replace it with a policy to be issued by Security Life Insurance Company of America.

For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.
Do not cancel your present policy until you have actually received your new policy and are sure you want to keep it.

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The above "Notice to Applicant" was delivered to me on:

_____ _____
(Date) (Applicant's Signature)

REP1000-APP

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OUTLINE OF COVERAGE

ONE LIFE DENTAL INSURANCE
Policy Form GH-1112

Read Your Policy Pages Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy and certificate provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY PAGES CAREFULLY!

Policy GH-1112 provides coverage for dental services. Coverage is segmented into various classes of benefit (Preventive, Basic, Major and Orthodontic if offered), and generally includes specific benefit frequency provisions and benefit waiting periods. Deductibles and coinsurance percentages apply to the various benefit classes. Please refer to the coverage schedule within your policy certificate for specific plan details.

Preventive, Basic and Major service categories are limited to specific maximum calendar year limit amounts. Orthodontic benefits (if offered) are limited to an annual and lifetime maximum amount.

Plans may be offered with or without a participating provider organization, please refer to your policy certificate for details.

Rate adjustments can occur at periodic intervals and is generally based on the experience.