

**EXCLUSIONS AND LIMITATIONS:** (continued) • made by any government entity unless the insured is required to pay; or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made; • related to prosthodontics. \*\*\*Some provisions, benefits, exclusions or limitations listed herein may vary depending on your state of residence.

**DEDUCTIBLE AMOUNT:** The Deductible is shown in the Dental Care Descriptions. The Deductible is an amount of covered dental charges incurred by each insured person for which no benefit will be paid.

**CALENDAR YEAR MAXIMUM:** The maximum amount payable for all Eligible Dental Expenses in any calendar year is shown in the Dental Care Descriptions. The Calendar Year Maximum will apply to each insured person.

**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; • the first of the month following your 60th birthday; • subject to the Grace Period, the last day of the month for which premium has been paid by You or on Your behalf; • the date the Policy ends.

**ELIGIBLE EXPENSES & EXPENSES INCURRED:**

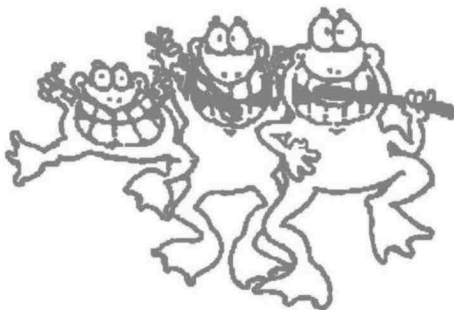
Expenses must be incurred while the Plan is in force and the person is covered by the Plan. To be an Eligible Expense, the dental services must be covered under the policy and be performed by: • a licensed Dentist or a licensed Physician performing dental services within the scope of his license; or • a licensed Dental Hygienist acting under the supervision and direction of a Dentist.

**PREDETERMINATION:** If the Course of Treatment will exceed \$300, We will require prior review. If you do not request a pre-determination review, We will pay the least expensive method of treatment regardless of method actually used except in an emergency.

**COPAY:** The Copay is the fixed dollar amount specified in the Schedule of Dental Care Descriptions that is payable by an Insured to a Provider at the time of service in connection with specific Covered Charges.

**POLICY NO:** DT-111, DT-128, M-9040

# The O N E



## Dental Plan For you & your family

Underwritten by  
Fidelity Security Life  
Insurance Company

# The ONE dental plan for you and your family

## Dental Care Descriptions

### Preventive Services - Class A 100% - UCR

#### no waiting periods

- Two routine Exams no less than 6 months apart
- Two routine Cleanings no less than 6 months apart
- Fluoride (Child to age 16) once per year

### Basic Services - Class B 80% - UCR

#### 6 month waiting period

- Bitewing X-rays (set of 4) no less than 6 months apart.
- Fillings
- Simple Extractions
- Full mouth x-rays once in a 36 consecutive month period.

### Major Services - Class C 50% - UCR

#### 12 month waiting period

- Endodontics
- Oral Surgery (Surgical Extractions & Impactions)
- Periodontics

### Major Services - Class D 50% - UCR

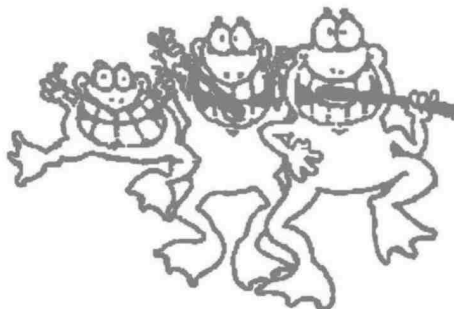
#### 24 month waiting period

- Crowns, Inlays, Onlays (single restoration)
- Bridges (treatment must begin after the effective date of coverage)
- Dentures (treatment must begin after the effective date of coverage)

### Deductibles/Co-Pays

- \$35 lifetime, Per Person - Class A
- \$50 calendar year, Per Person - Class B, C, & D combined
- \$10 per office visit co-pay, Per Person

**CHOOSE  
ANY  
DENTIST!**



### New rates effective June 1, 2006

	Per Adult	Per Child
Area 1	\$25.93	\$12.97
Area 2	\$29.13	\$14.57
Area 3	\$32.02	\$16.01
Area 4	\$34.90	\$17.45
Area 5	\$38.10	\$19.05
Area 6	\$40.98	\$20.49
Area 7	\$44.82	\$22.41
Area 8	\$51.23	\$25.61

### Miscellaneous

- > Calendar Yr Max. \$1000
- > 12 month rate guarantee

**EFFECTIVE DATE:** The Plan Effective Date is always the first of the month following approval by Fidelity Security Life Insurance Company.

AK	all zips	6	IA	other	1	NM	all zips	2
AR	other	1		500-503	2	NC	other	1
	720-722	2	KS	all zips	2		271-282	2
AZ	other	2	KY	all zips	2	ND	all zips	1
	850-853	3	MD	other	3	OH	other	2
CA	other	4		207-209	4		440-444	3
	900-904	7		210-212	4	OK	all zips	2
	905-912	5	MI	other	2	PA	other	2
	913-916	6		480-483	3		189-194	4
	917-925	5	MS	other	1	RI	all zips	4
	926-928	6		390-392	2	SC	all zips	1
	929-951	6	MO	other	1	TN	other	1
	952-958	5		630-633	2		370-374	2
CO	other	3	MT	all zips	2		380-383	2
	800-809	4	NE	other	1	TX	other	2
CT	063,067	4		680-681	2		750-753	3
	060-062	5	NV	other	3		760-767	3
	064-066	5		890-891	4		770-777	4
	068-069	6		893-894	4	UT	other	1
DE	all zips	4		895,896,897	4		840-841	3
DC	all zips	5	NJ	other	4	VA	other	2
GA	other	1		070-076	5		220-223	4
	300-303	3		078-079	5		233-237	3
HI	all zips	3				WV	all zips	2
IL	other	3				WI	all zips	2
	600-606	4				WY	all zips	2
IN	other	1						
	460-466	2						

Rates based on the 1st 3 numbers of zip


Not Available in all States

## PREMIUM CALCULATION

### Rate Information:

Premium \_\_\_\_\_  
 Monthly Administration Fee     \$5.00      
 One Time Enrollment Fee     \$5.00      
 Total Due w/ App. \_\_\_\_\_

## AGENT INFORMATION

Name Scott McElhaney  
 Company \_\_\_\_\_  
 SSN/Tax ID 526874299  
 Address PO Box 133  
 City, State, Zip Queen Creek, Az. 85242  
 Phone (480)926-1077  
 Fax (480)926-5377  
 E-Mail sales@Arizona-Insurance-Finder.com  
 Pay Commissions to Scott McElhaney  
 Signature 

Underwritten & Administered by: **Fidelity Security Life Insurance Company**  
 Kansas City, MO.

Distributed by: **Marketing Benefits, Inc.**  
 P.O. Box 1459  
 Orange Beach, AL 36561  
 (800) 811-1600  
 Email: bill@marketingbenefits.com

**Make checks payable to Fidelity Security Life Insurance Company and RETURN all forms and checks to:**

**General Agent**

<b>Tennessee</b>	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.
<b>Pennsylvania</b>	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.
<b>New Mexico</b>	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.
<b>New Jersey</b>	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
<b>Nebraska</b>	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 be guilty of insurance fraud.

### FRAUD WARNING NOTICE

(Continued from other side)

## EXCLUSIONS AND LIMITATIONS

Notwithstanding any provision in the Policy to the contrary, the Plan does not provide benefits for the following charges, services or supplies: • which, in the absence of insurance, the insured would not be required to pay; • related to self-inflicted injuries (while sane in Missouri), • related to war or an act of war, whether or not declared; • related to the insured's commission of a felony or an assault on another person; • related to a riot, nuclear accident, or a major disaster; • caused by, related to, or as a condition of employment, including self-employment. This exclusion applies even if Workers' Compensation or any Occupational Disease or similar law does not cover the charges; • which are more than Reasonable and Customary Charges; • which are incurred, or for which treatment began, before the insured's effective date of coverage or after the insured's termination of coverage, • related to congenital or development malformations existing when the insured's coverage became effective under the Plan; • which are not Medically Necessary, appropriate or are primarily for the cosmetic reasons; • which are Experimental/ Investigational; • related to surgical implants or transplants of any type (including prosthetic devices attached to them); • related to temporomandibular joint syndrome; • related to periodontal splinting; • related to facings on crowns or pontics posterior to the 2nd bicuspid; • for replacement of partial or full dentures, fixed bridge work, crowns, gold restorations and jackets more often than once in any 5 year period; • related to relining of dentures more often than once in any 2 year period; • related to lost, stolen, or missing dentures or bridges or for duplicates; • related to fixed or removable bridgework involving replacement of a natural tooth (or teeth) which was lost prior to the insured's effective date of coverage under the Plan. Benefits may be payable for bridgework required for loss of teeth while insured under the Plan, if such bridgework is not an abutment for non-covered bridgework; • related to prescription drugs and analgesia pre-medication: • related to charges for telephone consultations, failure to keep a scheduled appointment, to complete claim forms or attending physician statements, and any other services or supplies which are not part of the direct treatment of the insured; • which are not made by a Dentist; • related to dental education or training programs (this includes oral hygiene or plaque control programs); • related to counseling on diet and nutrition; • received from a provider who (i) is the insured's spouse, child brother, sister, parent or in-law, (ii) resides with the insured, or (iii) is acting outside the scope of his/her license; • caused by or related to an insured's military service, including service in a military reserve unit; • for services and supplies not included in a Covered Procedure; • related to orthodontia; • which are payable under any medical insurance; • related to the use of materials, other than fluorides or sealants, to prevent tooth decay; • for bite registrations; • bacteriologic cultures in connection with a covered dental service; or therapeutic injections administered by a Dentist; (continued)

Last Name, First Name, Initial	Social Security Number - -	Birth Date / /	Sex
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Home Address	Marital Status married <input type="checkbox"/> single <input type="checkbox"/> widowed <input type="checkbox"/> divorced <input type="checkbox"/>
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City	State	Zip Code	Applying for coverage applicant only <input type="checkbox"/> applicant+one <input type="checkbox"/> applicant+family <input type="checkbox"/>
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Billing address (if different)	Telephone number ( )	Email Address:
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City	State	Zip Code	Requested Effective Date
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Dependents to be covered Last name, First Name, MI	Sex	Birth Date	Dependents to be covered Last Name, First Name, Initial	Sex	Birth Date
1. Spouse			3. Child		
2. Child			4. Child		

Are any applicants (including dependents) covered under another dental plan?  Yes  No  
 If "YES", Carrier Name: \_\_\_\_\_

Will that other dental plan be terminated upon issuance of this dental plan?  Yes  No

All dependent children listed, over age {18},{22in North Dakota} are full-time students:  Yes  No  
 If "NO", who isn't? \_\_\_\_\_

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Notice: If you or your family members are covered by more than one dental plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

<b>Underwritten by:</b> Fidelity Security Life Insurance Company	<p><b>The Certificate provides dental benefits only. Review your Certificate carefully.</b></p> <p>I hereby represent that the above information is complete and accurate to the best of my knowledge and belief. {I understand and acknowledge that by applying for this group insurance I am also becoming a member of the United Associations of America Group Insurance Trust or a member of The National voluntary Benefit Trust.}</p> <p><b>{I hereby represent that I have reviewed the fraud warning notice (if applicable) on the reverse side of this application for my state of residence.}</b></p> <p>Applicant's Signature _____ Date _____</p>
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