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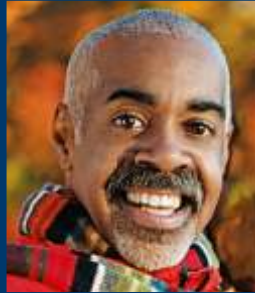
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Group Dental and Vision Plans



Affordable insurance for your employees and their families.

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

DENTAL PLANS

Available for Groups with as few as
Two Participating Employees

Dental Rate Discount for 50% Voluntary Participation

No Waiting Periods for Most Services

Choice of Multiple Plan Designs

Prior Plan Credit Available

Freedom to Use Any Dentist

VISION PLANS

Additional Network Discounts Available

No Waiting Periods

Choice of Multiple Plan Designs

EyeMed 
VISION CARE

EyeMed Network Including:

LENSCRAFTERS[®]

PEARLE VISION[®]

 **TARGET**
Optical

Sears
Optical

Rate Discount for Combined Dental
and Vision Package

Eligibility-Dental and Vision Plans

ELIGIBLE EMPLOYEE MEANS

An individual employed by a participating employer who works 20 hours or more per week, and who is considered an employee for Social Security purposes. Partners and Proprietors are also considered to be eligible employees.

ELIGIBLE DEPENDENT MEANS

- An employee's spouse; and
- Each unmarried child, from birth to age 19, who is living with You in a regular parent-child relationship and for whom You can claim an exemption on Your federal income tax.
- Each unmarried child, at least 19 years of age to 23 years of age for dental (or as required by law) and to age 25 for vision, who is primarily dependent on You for support and who is a full-time student. A full-time student is one who is enrolled at least 12 semester hours for credit in an accredited junior college, college or university.
- Each unmarried child at least 19 years of age (a) who is primarily dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation or physical handicap; (b) who was incapacitated and insured under the Policy on his 19th birthday; and (c) who continues to be incapacitated beyond his 19th birthday.

INELIGIBLE FIRMS

Band or orchestras; barber and beauty shops; cocktail lounges; dental offices/labs; optical offices/labs; entertainers; massage parlors; parking lots and garages; real estate sales; taxi companies; groups where there are not employer/employee relationships; and groups where more than half the employees are related by blood or marriage.

This list of ineligible firms is representative only and not all-inclusive. The insurance company reserves the right to reject any firm.

General Information-Dental and Vision Plans

PREMIUMS, RENEWABILITY

Applicable Dental Premium Rates are guaranteed for each Employer Group for 12 months from date of issue. Applicable Vision Premium Rates are guaranteed for each Employer Group for 24 months from the date of issue. Thereafter, rates are subject to change in accordance with the Master Policy. Coverage is renewable as long as eligibility criteria are satisfied and premiums are paid when due.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following dates: (a) the last day of the month in which You cease to be eligible for coverage; (b) the last day of the month in which Your Dependent is no longer a dependent as defined; (c) 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 (d) the date the Master Policy ends.

COORDINATION OF BENEFITS

This Plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits.

General Information-Dental Plans

PARTICIPATION DISCOUNT

In the event the final dental employee participation reaches the greater of 3 employees or 50% of the eligible employees, your monthly premium rates charged may be reduced by 10%. Final approval of this discount is to be made by the Company. This discount does not apply to the Employer Paid rates.

EFFECTIVE DATE

When a firm joins the Trust, the insurance for its current employees will be effective on the date approved by the insurance company. Future new employees will become insured on the first of the month following the completion of the probationary period selected by the employer. A completed enrollment form must be received within 31 days of new employee eligibility. An employee who does not enroll when initially eligible is considered a "late entrant." A late entrant is eligible to enroll in the program as a "new employee" on the Plan's Anniversary Date or immediately if a qualifying event occurs.

REASONABLE AND CUSTOMARY

Reasonable and Customary means the usual, customary and regular charges for the area where such expenses are incurred.

Benefit Provisions, Limitations and Exclusions Dental and Vision Plans

ELIGIBLE EXPENSES

We will pay for Eligible Expenses You Incur for Yourself or on Behalf of Your insured Dependent. Expenses must be incurred while the Policy is in force and the person is covered by the Policy. The description of Eligible Expenses is shown in the Coverage Schedule. To be an **Eligible Dental** Expense, the dental service or procedure must be performed by a licensed Dentist, Physician or Dental Hygienist. To be an **Eligible Vision** Expense, the vision service must be performed by an optometrist, an ophthalmologist, or an optician.

EXPENSES INCURRED

An **Eligible Dental** Expense is considered incurred on the following dates: For full and partial dentures - the date the final impression is taken; for fixed bridges, crowns, inlays and onlays - the date the teeth are first prepared; for root canal therapy - the date the pulp chamber is opened; for periodontal surgery - the date surgery is performed; for all other services - the date the service is performed. An **Eligible Vision** Expense is considered incurred on the date the vision service is performed.

Benefit Provisions, Limitations and Exclusions Dental Plans

DEDUCTIBLE AMOUNT

The calendar year Deductible, if any, is shown in the Coverage Schedule. The Deductible is an amount of eligible charges you must incur for Yourself or on behalf of Your insured Dependent(s) before we can begin paying benefits.

CALENDAR YEAR MAXIMUM

The maximum limit payable for all Eligible Expenses in any calendar year is shown in the Coverage Schedule. The Calendar Year Maximum, if any, will apply to each person covered under the Policy.

PRETREATMENT REVIEW

If the Course of Treatment will exceed the amount shown in the Coverage Schedule, We will request 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.

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 charges for the less expensive treatment.

MISSING TOOTH

When covered under your plan, benefits are provided for placement of dentures, fixed bridgework, implants or the addition of teeth to existing dentures only when the service includes replacement of a natural tooth extracted or lost while covered under this plan. This limitation ends after the individual receiving care has been covered under this plan for 36 consecutive months.

CREDIT FOR PRIOR TIME (CPT)

Credit toward satisfaction of any benefit year class may be given for the length of time an employee was covered under the employer's prior dental insurance plan, provided there is no interruption in coverage between the prior plan and the replacement plan. The insured applying for CPT must have been covered for the same benefit classes under the prior plan in order to receive credit under the new plan. In other words, if the employer's prior plan did not provide Major or Orthodontic class coverage and the new plan provides both, CPT may not be given for the class not previously provided.

CPT is given individually to each person (employee, spouse or child) covered. Any new employee and/or dependents added or subsequent to the group's effective date of this coverage, will not receive CPT. The agent has no authority to grant CPT or to waive the waiting period provision of the Plan.



GemStar® Group Dental and Vision Plans

Dental Benefits	Plan I	Plan II	Plan III
Class A - Preventive Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (to age 16)			
Benefit Year One	100%	80%	80%
Benefit Year Two	100%	80%	100%
Benefit Year Three and Each Benefit Year Thereafter	100%	80%	100%
Deductible - Lifetime per Insured	\$50	\$50	\$50
Waiting Period	None	None	None
Class B - Basic X-rays, Fillings, Simple Extractions, Sealants (to age 16)			
Benefit Year One	50%	50%	50%
Benefit Year Two	60%	50%	80%
Benefit Year Three and Each Benefit Year Thereafter	80%	50%	80%
Deductible - Each Calendar Year per Insured*	\$50/year	\$50/year	\$75/year
Waiting Period	None	None	None
Class C - Major Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Year One	30%	25%	Not Available
Benefit Year Two	50%	50%	Not Available
Benefit Year Three and Each Benefit Year Thereafter	50%	50%	Not Available
Deductible - Each Calendar Year per Insured*	\$50/year	\$50/year	-
Waiting Period	None	None	-
Class D - Orthodontics Straightening of Teeth (for children under age 19)			
Benefit Year One	0%	Not Available	Not Available
Benefit Year Two	50%	Not Available	Not Available
Benefit Year Three and Each Benefit Year Thereafter	50%	Not Available	Not Available
Deductible	None		
Waiting Period	12 Months		
Calendar Year Maximum for Classes A, B and C Combined	\$1,500	\$1,000	\$1,000
Calendar Year Maximum for Class C - Major Services	\$750	\$500	N/A
Calendar Year Maximum for Class D	\$500	-	-
Lifetime Maximum per Child for Class D	\$1,000	-	-
* Class B & C Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.			

PLAN I NOT AVAILABLE IN SOUTH DAKOTA

The above plans provide for an increase in coinsurance levels based upon each Benefit Year of coverage. Benefit Year begins with each insured's effective date and continues for 12 months. Each primary insured and/or dependent will have his own Benefit Year beginning with his specific effective date of coverage.

This plan reimburses at the above percentages for covered dental expenses based upon the Reasonable and Customary (R&C) fees for those covered expenses.

To learn more about our products and order supplies visit our dedicated website.

www.starsdental.com



866-847-1120

IN NETWORK BENEFITS

The EyeMed Access Network includes such familiar names as **Lenscrafters, Pearle Vision, Sears Optical, and Target Optical** along with thousands of independent optometrists, ophthalmologists and opticians.

Vision Benefits	Plan I 9657933	Plan II 9657941	Plan III 9657974
EYE EXAMINATION			
Frequency	Once every 12 months	Once every 12 months	Once every 12 months
Insureds Co-pay	None	\$10	\$10
EYEGGLASS LENSES			
Frequency	Once every 24 months	Once every 12 months	Once every 24 months
Insureds Co-pay	None	\$10	\$20
FRAMES			
Frequency	Once every 24 months	Once every 12 months	Once every 24 months
Insureds Co-pay	None	\$0	\$0
CONTACTS (In lieu of eyeglass lenses)			
Frequency	Same as eyeglass lenses	Same as eyeglass lenses	Same as eyeglass lenses
Insureds Co-pay	Same as eyeglass lenses	Same as eyeglass lenses	Same as eyeglass lenses

OUT OF NETWORK BENEFITS

The greatest benefit is realized when network providers are used, but members may choose out of network providers, paying the provider and receiving reimbursement from the plan according to the schedule below. Call the toll-free number for a claim form.

	Plan I	Plan II	Plan III
EYE EXAMINATION			
We Pay Up to	\$30	\$25	\$25
FRAMES			
We Pay Up to	\$40	\$40	\$40
EYEGGLASS LENSES- single vision			
We Pay Up to	\$25	\$20	\$20
EYEGGLASS LENSES- bifocal			
We Pay Up to	\$45	\$40	\$30
EYEGGLASS LENSES- trifocal			
We Pay Up to	\$55	\$50	\$40
CONTACTS (In lieu of glasses)			
We Pay Up to	\$75	\$70	\$60

WHAT THE BENEFITS INCLUDE

Eye Examination

A routine, complete eye examination, refraction and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures which are the responsibility of the member.

Eyeglass Lenses

Standard uncoated plastic lenses of any size or power.

Frames

Any frame up to a regular retail value of \$100. Frames above \$100 retail are available at an additional charge.

Contact Lenses

Any pair of contact lenses up to a regular retail price of \$100 obtained from a network provider or the mail order program.

Contact lenses above \$100 are available at an additional charge.

ADDITIONAL BENEFITS (In Network Only) Lens Options (add to lens prices above)

	Co-Payment		Co-Payment
UV Coating	\$15	Tint	\$15
Scratch Resistance	\$15	Polycarbonate	\$40
Anti-Reflective	\$45	Standard Progressive	\$65
Other Add Ons	20% Retail Discount		

LASIK - NON-INSURED DISCOUNT BENEFIT

The EyeMed Access network provides discounts to insureds interested in LASIK - A LASER VISION CORRECTION PROCEDURE. This non-insured benefit is offered at savings of 15% off the regular retail price or 5% off the promotional price when using the network.

UNDERWRITING GUIDELINES

Rates are guaranteed for a period of TWO YEARS from the effective date.
Full-time students up to age 25 are eligible as dependents.
Annual open enrollment.

For Information or to locate a participating doctor call 866-723-0513 or visit www.enrollwiththeyemed.com/access.

NOT AVAILABLE IN WASHINGTON

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 Contract.

A full explanation of dental benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Dental Policy Form GH-1112 issued to the Employer's Voluntary Benefit Insurance Trust.

A full explanation of vision benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Vision Policy Form GH-1157 for all states except IA & MN. A full explanation of vision benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Vision Policy Form GH-1154 for IA & MN. The policyholder may be a trustee group policyholder in some states.

Benefits may vary in different states. GemStar Dental and Vision Plans may not be available in all states.

No agent has the authority to change any benefits, to bind coverage with Security Life Insurance Company of America, or to promise a certain effective date.

VISION EXPENSES NOT COVERED

Limitations -In no event will payment exceed the lesser of:

- The actual cost of covered Services or Materials; or
- the limits of the Policy, shown in this Schedule.

Exclusions -We will not cover:

- Orthoptic or vision training and any associated supplemental testing;
- plano lenses;
- lens coatings;
- two pairs of glasses, in lieu of bifocals or trifocals;
- medical or surgical treatment of the eyes;
- any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- any injury or illness when covered under any Workers Compensation or similar law, or which is work-related;
- no-line bifocal or progressive lenses;
- photo-chromatic lenses;
- sub-normal vision aids or non-prescription lenses;
- services rendered or Materials purchased outside the U.S. or Canada, unless:
 - a. the Insured resides in the U.S. or Canada; and
 - b. the charges are incurred while on a business or pleasure trip.
- eyeglasses when the changes in prescription is less than .5 Diopter;
- charges in excess of the Usual and Customary charge for the Service or Materials;
- charges incurred after:
 - a. the Policy ends; or
 - b. the Insured's coverage under the Policy ends, except as stated in the Policy;
- experimental or non-conventional treatment or device;
- spectacle lens treatments or "add-ons", except solid tints(#1 and #2), and oversize lenses;
- high index lenses of any material type;
- lost or broken Materials, except when replaced at normal intervals when Services are available.

DENTAL EXPENSES NOT COVERED

- for overdentures and associated procedures;
- for charges in excess of those considered Reasonable and Customary;
- for cosmetic procedures;
- for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
- for implants and for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication;
- for oral hygiene instructions; and for: plaque control, completion of a claim form, acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs;
- for services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us;
- for procedures that are begun, but not completed;
- for services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
- 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 a condition covered under any Worker's Compensation Act or similar law;
- 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 included within Coverage Schedule;
- for services rendered prior to the date the Insured is covered under the Policy;
- for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD);
- for hospital services;
- for any unmarried child age 19 years of age and over unless he is dependent upon You for support, while a full-time student. A full-time student is one who is enrolled for 12 semester hours for credit in an accredited junior college, college or university. Any exception for a full-time student will end at age 23;
- if You voluntarily end Your insurance You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
- charges for infection control, sterilization, and waste disposal.





EMPLOYER ELECTION FORM

How to enroll...

- 1) Complete all sections of the Employer Election Form based upon the plan selected. Be sure to complete both sides of the election form and sign/date where applicable.
- 2) Obtain signed enrollment forms from each employee electing coverage. Review each enrollment form, completing the top section of each form with applicable employer information.
- 3) If prior dental plan credit is requested, attach copy of the most recent billing statement from the prior carrier indicating coverage for each employee. This statement must also include the effective date of the prior coverage from which appropriate credit shall be calculated.

- 4) Determine your initial monthly premium due, **make check payable to: Security Life Insurance Company of America**

Authorization To Convert Your Check To An Electronic Funds Transfer Debit – By sending your check to us, you authorize **Security Life Insurance Company of America** to convert the check into an electronic funds transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment.

- 5) Submit Employer Election Form, Employee Enrollment Forms, Prior Plan details (if applicable), and initial premium check to:
GemStar Group Plans
P.O. Box1064, Schenectady, NY 12301

If accepted, the undersigned Employer agrees: (a) To make such benefits available to all present employees and all employees becoming eligible in the future; and (b) To make payroll deductions as required for the plan as are applicable to the employees. The undersigned Employer further agrees that only those full-time employees who meet the *eligibility requirements (as defined under Eligibility within the brochure) are to be included, and that participation requirements must be met before the benefit plan can be made effective. The employer agrees that not less than two (2) non-related employees of the employer's eligible employees must be enrolled in the GemStar Dental and/or Vision Plan to prevent cancellation of coverage. This plan does not require any contribution from the employer. To be eligible for the Employer Paid premium rates illustrated, the employer agrees to contribute no less than 75% of the employee only premium or 50% of the combined employee/dependent premiums.

The undersigned Employer requests that benefits be made available to all employees subject to the following conditions:

- a) No coverage for any employees shall take effect until this Agreement and the employee's individual Enrollment Cards are accepted by the Company and the initial premium paid; and
- b) Employer agrees to remit regularly, in advance, the required premium payments to the Administrator and acknowledges and agrees that this Plan is established under and is subject to the provision of the Employee Retirement Income Security Act (ERISA), as amended. The undersigned Employer is the Plan Administrator as defined in ERISA, as amended.

EMPLOYER INFORMATION

Name of Employer: _____ Send Correspondence to: _____

Address _____ City: _____ State _____ Zip Code: _____

Phone Number: () _____ Fax: () _____

Nature of Business _____ [] Corporation [] Partnership [] Sole Proprietorship [] Other

Subsidiaries and Affiliates Included [] Yes [] No

Name and Address of Subsidiaries & Affiliates whose employees are to be covered: _____

Effective Date Requested: _____ (limited to 1st or 15th of the month)

INITIAL PROBATIONARY PERIOD

- (a) For current employees - NONE
- (b) For future employees: _____ DAYS/MONTHS

New hires to be effective on the first of the Month following probationary period

PLAN SELECTION

DENTAL ADOPTION AND PARTICIPATION AGREEMENT

- [] Plan 1 [] Plan 2 [] Plan 3
[] Voluntary [] Employer Paid

PARTICIPATION AND CONTRIBUTIONS

The undersigned Employer agrees to contribute:

EMPLOYEE: \$ _____ /OR _____ %
EMPLOYEE/SPOUSE: \$ _____ /OR _____ %
EMPLOYEE/CHILD(REN): \$ _____ /OR _____ %
EMPLOYEE/FAMILY: \$ _____ /OR _____ %

There are initially _____ full-time employees of which _____ are enrolled in this Plan.

CURRENT DENTAL PLAN

- Is this group currently enrolled under another group dental program? [] Yes [] No
Are CPT Benefits requested? [] Yes [] No
Did you include a copy of the current Plan and a copy of the last billing? [] Yes [] No

The undersigned Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under Group Dental Policy GH-1112-38070-02 insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

Authorized Signature _____

Date _____ E-Mail _____

VISION APPLICATION (not available in Washington)

- [] Plan 1 [] Plan 2 [] Plan 3
[] Voluntary [] Employer Paid

PARTICIPATION AND CONTRIBUTIONS

The undersigned Employer agrees to contribute:

EMPLOYEE: \$ _____ /OR _____ %
EMPLOYEE/SPOUSE: \$ _____ /OR _____ %
EMPLOYEE/CHILD(REN): \$ _____ /OR _____ %
EMPLOYEE/FAMILY: \$ _____ /OR _____ %

There are initially _____ full-time employees of which _____ are enrolled in this Plan.

It is agreed that the Policy will become effective at rates to be determined by Us, provided the application is accepted by Us. The applicant declares that to the best of its knowledge and belief that statements and answers are complete and true.

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.

Authorized Signature _____

Date _____ E-Mail _____

GHA-1157

PRODUCER'S STATEMENT – I hereby certify that all the information contained in this Employer Election Form is correct to the best of my knowledge and I know nothing unfavorable about this entity or any individual proposed for participation. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the entity.

Producer Name _____ SS#/TIN# _____ Appointed with Security Life? [] Yes [] No
Street Address _____ City _____ State _____ Zip _____
Phone Number _____ Email _____ Signature _____

GEMSTAR MONTHLY PREMIUM RATES

For Effective Dates August 1, 2008 through March 1, 2009

Groups of over 100 eligible employees must be submitted to the Home office for Review.

Increase all rates 20% for schools and governmental bodies.

		Group Dental Base Rates*									GROUP VISION BASE RATES*			
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Plan 1	Plan 2	Plan 3	Plan 4	
Voluntary	Plan 1	Employee Only	\$ 20.40	\$ 22.30	\$ 24.60	\$ 27.00	\$ 29.70	\$ 32.70	\$ 35.80					\$ 39.50
		Employee+Spouse	\$ 41.20	\$ 45.20	\$ 49.70	\$ 54.60	\$ 60.10	\$ 66.10	\$ 72.50	\$ 80.00	Employee+Spouse	\$ 11.50		
		Employee+ Child(ren)	\$ 48.70	\$ 53.40	\$ 58.60	\$ 64.40	\$ 70.90	\$ 77.90	\$ 85.60	\$ 94.30	Employee+ Child(ren)	\$ 9.90		
		Employee + Family	\$ 73.80	\$ 80.90	\$ 88.90	\$ 97.80	\$ 107.60	\$ 118.30	\$ 129.90	\$ 143.20	Employee + Family	\$ 16.30		
	Plan 2	Employee Only	\$ 15.80	\$ 17.30	\$ 19.00	\$ 20.90	\$ 23.00	\$ 25.20	\$ 27.70	\$ 30.50	Employee Only	\$ 7.50		
		Employee+Spouse	\$ 31.90	\$ 34.90	\$ 38.30	\$ 42.20	\$ 46.40	\$ 51.00	\$ 56.00	\$ 61.70	Employee+Spouse	\$ 14.10		
		Employee+ Child(ren)	\$ 32.90	\$ 36.10	\$ 39.70	\$ 43.70	\$ 48.10	\$ 52.80	\$ 58.00	\$ 63.90	Employee+ Child(ren)	\$ 12.20		
		Employee + Family	\$ 52.40	\$ 57.40	\$ 63.10	\$ 69.40	\$ 76.40	\$ 84.00	\$ 92.20	\$ 101.60	Employee + Family	\$ 20.10		
	Plan 3	Employee Only	\$ 11.80	\$ 12.90	\$ 14.20	\$ 15.60	\$ 17.20	\$ 18.90	\$ 20.70	\$ 22.90	Employee Only	\$ 4.70		
		Employee+Spouse	\$ 23.90	\$ 26.10	\$ 28.70	\$ 31.60	\$ 34.70	\$ 38.20	\$ 41.90	\$ 46.30	Employee+Spouse	\$ 8.60		
		Employee+ Child(ren)	\$ 24.70	\$ 27.00	\$ 29.70	\$ 32.70	\$ 35.90	\$ 39.50	\$ 43.40	\$ 47.80	Employee+ Child(ren)	\$ 7.40		
		Employee + Family	\$ 39.20	\$ 43.00	\$ 47.30	\$ 51.90	\$ 57.20	\$ 62.80	\$ 68.90	\$ 76.10	Employee + Family	\$ 12.00		
Employer Paid	Plan 1	Employee Only	\$ 17.70	\$ 19.40	\$ 21.30	\$ 23.50	\$ 25.80	\$ 28.40	\$ 31.10	\$ 34.40	Employee Only	\$ 5.40		
		Employee+Spouse	\$ 35.90	\$ 39.30	\$ 43.20	\$ 47.50	\$ 52.30	\$ 57.50	\$ 63.10	\$ 69.60	Employee+Spouse	\$ 10.00		
		Employee+ Child(ren)	\$ 42.30	\$ 46.40	\$ 50.90	\$ 56.10	\$ 61.70	\$ 67.80	\$ 74.40	\$ 82.10	Employee+ Child(ren)	\$ 8.60		
		Employee + Family	\$ 64.20	\$ 70.40	\$ 77.30	\$ 85.10	\$ 93.60	\$ 102.90	\$ 113.00	\$ 124.50	Employee + Family	\$ 14.00		
	Plan 2	Employee Only	\$ 13.70	\$ 15.00	\$ 16.50	\$ 18.20	\$ 20.00	\$ 22.00	\$ 24.10	\$ 26.60	Employee Only	\$ 6.60		
		Employee+Spouse	\$ 27.70	\$ 30.30	\$ 33.40	\$ 36.70	\$ 40.40	\$ 44.40	\$ 48.70	\$ 53.70	Employee+Spouse	\$ 12.20		
		Employee+ Child(ren)	\$ 28.60	\$ 31.40	\$ 34.60	\$ 38.00	\$ 41.80	\$ 45.90	\$ 50.40	\$ 55.60	Employee+ Child(ren)	\$ 10.50		
		Employee + Family	\$ 45.50	\$ 50.00	\$ 54.90	\$ 60.40	\$ 66.40	\$ 73.00	\$ 80.10	\$ 88.40	Employee + Family	\$ 17.30		
	Plan 3	Employee Only	\$ 10.30	\$ 11.30	\$ 12.30	\$ 13.60	\$ 14.90	\$ 16.40	\$ 18.00	\$ 19.90	Employee Only	\$ 4.10		
		Employee+Spouse	\$ 20.70	\$ 22.70	\$ 24.90	\$ 27.50	\$ 30.20	\$ 33.20	\$ 36.50	\$ 40.20	Employee+Spouse	\$ 7.50		
		Employee+ Child(ren)	\$ 21.40	\$ 23.50	\$ 25.80	\$ 28.40	\$ 31.20	\$ 34.40	\$ 37.70	\$ 41.60	Employee+ Child(ren)	\$ 6.50		
		Employee + Family	\$ 34.10	\$ 37.40	\$ 41.00	\$ 45.20	\$ 49.70	\$ 54.60	\$ 59.90	\$ 66.20	Employee + Family	\$ 10.40		

DENTAL ZIP CODE AREA CHART											
State		State		State		State		State		State	
Zip	Area	Zip	Area	Zip	Area	Zip	Area	Zip	Area	Zip	Area
Alabama		California		Delaware		Michigan		Nebraska		North Dakota	
350-355	3	915-916	8	All Areas	2	480-483	2	All Areas	1	580-581	2
359	3	917-918	4	Dist Columbia		490-491	2	Nevada		All Other	1
All Other	1	919-927	6	All Areas	6	488-489	3	890-891	2	Ohio	
Alaska		930-934	6	Hawaii		All Other	1	894-895	6	All Areas	1
995-996	8	939	6	All Areas	3	Mississippi		898	6	Oklahoma	
All Other	6	943-948	4	Idaho		390-392	2	All Other	4	740-743	2
Arizona		949, 961	6	All Areas	1	All Other	1	New Mexico		All Other	1
856-857	2	956-958	3	Indiana		Missouri		881	2	Oregon	
864	2	959	4	463-464	2	640-641	2	882	5	977	3
All Other	1	All Other	5	473	3	644-649	2	All Other	1	978	1
Arkansas		All Other	1	All Other	1	All Other	1	North Carolina		All Other	2
All Areas	1	803	4	Kansas		Montana		277	2	South Carolina	
California		808-810	4	660-662	2	590-591	1	286	3	All Areas	1
900-905	7	All Other	1	All Other	1	599	2	287-289	2	Tennessee	
906-914	6					All Other	3	All Other	1	373-374	2
										All Other	1

****If the group is electing both of the dental and vision coverage's, the base rates may be reduced by 5% (multiply each base rate by .95). In order to qualify for this discount at least 2 employees must elect dental coverage and at least 2 employees must elect vision coverage.**

Determine your monthly dental premium	*Dental Base Rates	**Discount for electing both dental and vision		Add For Waiting Period Credit?		Discount for 50% Participation? (Voluntary Only)		Dental Monthly Premium Total	# of Employees	Dental Subtotal
		[] Yes	[] No	[] Yes	[] No	[] Yes	[] No			
Employee Only	\$	X.95		X 1.14		X .90		\$		\$
Employee + Spouse	\$	X.95		X 1.14		X .90		\$		\$
Employee + Child(ren)	\$	X.95		X 1.14		X .90		\$		\$
Employee + Family	\$	X.95		X 1.14		X .90		\$		\$
Initial Dental Premium due										\$

EyeMed Vision is not available in Washington State

Determine your monthly vision premium	*Vision Base Rates	**Discount for electing both dental and vision		Vision Monthly Premium Total	# of Employees	Vision Subtotal
		[] Yes	[] No			
Employee Only	\$	X.95		\$		\$
Employee + Spouse	\$	X.95		\$		\$
Employee + Child(ren)	\$	X.95		\$		\$
Employee + Family	\$	X.95		\$		\$
Initial Vision Premium Due						\$

Initial Remittance	
Dental	\$
Vision	\$
Total Due \$	
<i>Payable to Security Life Insurance Co of America</i>	

GemStar Group Enrollment Card: Return completed form to your employer

Employer Information (TO BE COMPLETED BY THE EMPLOYER)

Name and Address of Employer or Organization (if applicable)	Full-Time Hire Date
	Telephone Number

FOR COMPANY USE ONLY
Effective Date: ___/___/___
Plan Code: _____
Group #/ Division _____
CPT: _____

Employee Information (PLEASE PRINT CLEARLY)

Coverage Election: Dental Only Vision Only Dental & Vision
 I apply for coverage on: Employee Only Employee and Spouse
 Employee and Child(ren) Employee and Family

Last Name	First Name	Initial
Address	Telephone Number	
City	State	Zip

Birth Date: / /
Sex: M [] F []
Marital Status
Married [] Single []

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW					
Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

Please note: If additional dependent information is necessary please attach a separate sheet of paper

- Does Spouse have a dental plan: Yes No
 With whom? _____
 If answer is "Yes", are dependents enrolled under spouses plan? Yes No
- Do you claim a tax exemption for all eligible dependents listed above? Yes No
 If no, who is not? _____
- All dependent children above over age 18 are full time students. Yes No
 If not, who is not? _____

Group Dental Coverage is provided under the Group Dental Insurance Policy GH-1112 issued to the Employers' Voluntary Benefit Insurance Trust insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

Group Vision Coverage is provided under the Group Vision Policy GH-1157 or under the Group Vision Policy GH-1154 issued to the Group Policyholder (policyholder may be a trustee group policyholder in some states) insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

By my signature below, I hereby apply for the coverage or coverage's selected above. I certify that I have read the applicable Fraud Notice below. I also hereby authorize payroll deductions from my earnings for any contributions required. This Authorization remains in effect until revoked by me in writing.

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

Employee Signature

Date

IMPORTANT FRAUD NOTICES

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.

STATE SPECIFIC NOTICES

Arkansas/ 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 in prison.

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 policy holder 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.

District of Columbia - WARNING: 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.

Kentucky - Any person who knowingly and with intent to defraud any insurer 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.

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.

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.

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.

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.

Virginia - 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.