

included); prior to the date the Insured is covered under the Policy; for the diagnosis or treatment of TMJ; for hospital services.

**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 charge for the less expensive treatment.

### General Information

**Eligibility:** Individuals over the age of 18 who are full-time employees (working 20 hours or more per week), and their eligible dependents (spouse and unmarried children from birth to age 19; to age 23 if the child is a full-time student).

**Deductible Amount:** The Deductible is shown in the Coverage Schedule. The Deductible is an amount of covered dental charges incurred by an insured person for which no benefits will be paid.

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

**Pretreatment Review:** If the course of treatment will exceed \$300, we will require 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.

**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, as defined; 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 the date the Policy ends.

### How to apply:

1. The employer should complete the Adoption and Participation Agreement.
2. An enrollment card needs to be completed by each employee.
3. Make a check for the first month's remittance as instructed on the Adoption and Participation Agreement, and send to:

Pearl & Associates, Ltd.  
1200 East Glen Avenue  
Peoria Heights, IL 61614

Administered by:



Pearl & Associates, Ltd.  
1200 East Glen Avenue • Peoria Heights, IL 61614  
www.pearlins.com • Fax: (309) 688-5444  
**1-800-289-8170**

Underwritten by:

**Security Life Insurance Company of America** of Minnetonka, MN,  
in these states:

AK, AZ, AR, CA, CO, DE, DC, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, MN, MI, MS, MO, MT, NC, ND, NV, NE, NM,  
OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, WV, WI, WY

**The Baltimore Life Insurance Company** of Owings Mills, MD,  
in these states:

AL, CT, FL, ME, MA, NC, NH, NJ, RI, VT

Product not available in all states. Contact Pearl & Associates for product availability in your State.

NOTICE: This brochure provides a very brief description of some important features of this Plan. It is not the Insurance Contract nor does it represent the Insurance Contract. For Security Life, a full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance, Policy Form Series GH-1112(97), issued to the Employers Voluntary Benefit Insurance Trust. For Baltimore Life, a full explanation of benefits, exceptions and limitations is contained in the Policy Certificate 5327C and its state-specific versions. Policy not available in all states.

Form #S10296

000748-0700

Insurance for  
**Groups**



**Pearl**  
*Dependable Group*  
**Dental**<sup>TM</sup>  
*Insurance Protection for Groups of Five or More*

## Program Highlights

- Choose your own dentist
- Affordable rates
- Zero deductible for Preventive Services and Orthodontic Services
- Covers Basic, Special, Major and Orthodontic Services (waiting periods may apply)
- \$1,000 of benefits per insured person, per year

**Enhance** your employee benefit package with Pearl Dependable Group Dental. Your employees will receive a complete dental protection program, one that offers substantial improvements over an individual plan. For instance, Orthodontic services are covered—without a deductible. In addition, Pearl Dependable Group Dental offers short waiting periods. For Preventive and Basic care, the coverage starts on the very first day of effectiveness. Best of all, you'll be able to provide this valuable and appreciated coverage to your employees at a very competitive per employee cost. Please take a moment to review the coverage information and then apply.

## Plan Information

**Eligible Expenses:** Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To be an Eligible Expense, the dental services must be performed by: a licensed Dentist acting within the scope of his/her license; a licensed Physician performing dental services within the scope of his/her license; or a licensed dental hygienist acting under the supervision and direction of a dentist.

**Expenses Incurred:** An Eligible Expense is considered incurred on the following dates: for full and partial dentures—on the date the final impression is taken; for fixed bridges, crowns, inlays and onlays—on the date the teeth are first prepared; for root canal therapy—on the date the pulp chamber is opened; for periodontal surgery—on the date surgery is performed; for orthodontic services—on the date the appliance or bands are inserted or on the date a one-step orthodontic procedure is performed; for all other services—on the date the service is performed.

**Expenses Not Covered:** No benefits will be paid for expenses incurred: for charges in excess of those considered reasonable and customary; for overdentures and associated procedures; for cosmetic procedures, for the replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function; for implants; and for (a) the replacement of lost or stolen appliances; (b) the replacement of orthodontic retainers; (c) athletic mouthguards; (d) precision or semi-precision attachments; (e) denture duplication; or for (f) sealants; for oral hygiene instructions; and for (a) plaque control; (b) the completion of claim form; (c) acid etch; (d) broken appointments; (e) prescription or take-home fluoride; or for (f) diagnostic photographs. In addition, no benefits will be paid for expenses incurred: for services not completed by the end of the month in which coverage terminates, unless continuation of coverage has been requested by us; for procedures that are begun, but not completed; for those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge; 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 care or treatment of a condition for which you are entitled to or eligible for benefits under any Workers' Compensation Act or similar law; that are applied toward satisfaction of a deductible, if any; 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 specifically

## Pearl Dependable Group Dental Insurance – benefits at a glance

Maximum Benefits	\$1,000 per insured person per calendar year	
Deductible Amount	No deductible for Preventive and Ortho. All others, \$50 per insured person per calendar year	
<b>Benefits Payable*</b>		
First 12 Months	Thereafter	
100% Preventive 50% Basic 50% Special No Major No Ortho	100% Preventive 50% Basic 50% Special 50% Major 50% Ortho**	

### Preventive Services

*No waiting period*  
Fluoride (to age 16), exams, cleanings

### Basic Services

*No waiting period*  
X-Rays, fillings, simple extractions

### Special Services

*6 month waiting period*  
Oral surgery (surgical extractions and impactions), endodontics, periodontics

### Major Services

*12 month waiting period*  
Crowns, bridges, dentures

### Ortho Services

*12 month waiting period*  
Straightening of teeth (to age 19)

\*\*Orthodontic Services limited to a maximum benefit of \$350 per calendar year per insured person (under age 19) and to \$1,000 per lifetime. Deductible amount does not apply to Ortho Services.

\*Based on Reasonable and Customary charges. Reasonable and Customary charges are fees that do not exceed the general level of charges being made by other providers of dental services in the State where the charge is incurred.



Send Adoption and Participation Agreement, Enrollment Cards and Initial Remittance to: Pearl & Associates, Ltd.  
1200 East Glen Avenue  
Peoria Heights, IL 61616.

## Adoption and Participation Agreement

The undersigned Employer hereby requests to participate in the Employer's Voluntary Benefit Insurance Trust, and hereby accepts and agrees to be bound by the terms and conditions as now in effect, or hereafter may be modified.

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 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 five (5) employees or 100% of the employer's eligible employees (larger number) must be enrolled in the Plan to prevent cancellation of coverage.

<p>1. Employer firm name _____</p> <p>2. Address _____</p> <p>3. Phone: _____ Fax: _____ Correspondence to: _____</p> <p>4. Employer firm is a:  <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship  <input type="checkbox"/> Association <input type="checkbox"/> Trustee/Union <input type="checkbox"/> Other           Nature of business _____</p> <p>5. Name and address of Firms (affiliates &amp; subsidiaries) whose employees are to be covered:          _____          _____          _____</p> <p>6. Initial waiting period          (a) For employees on effective date—None          (b) For future employees: <input type="checkbox"/> 1 mo. <input type="checkbox"/> 2 mo.'s <input type="checkbox"/> 3 mo.'s   <input type="checkbox"/> Other _____          New hires to be effective on the first of month following waiting period.  <small>Maximum waiting period for future employees may not exceed six months.</small></p> <p>7. Is this group currently enrolled under another group dental program?   <input type="checkbox"/> Yes <input type="checkbox"/> No Identify _____          Did you include a copy of current plan and a copy of the last billing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Are CPT benefits requested? <input type="checkbox"/> Yes <input type="checkbox"/> No (CPT not available to groups with less than ten insured employees).</p> <p>8. Desired Effective Date (limited to the 1<sup>st</sup> or 15<sup>th</sup> of month): _____</p> <p>9. 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.</p> <p>10. 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 Plan Coordinator 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 provisions of the Employee Retirement Income Security Act (ERISA), as amended. The undersigned Employer is the Plan Administrator as defined in ERISA, as amended.</p> <p>Employer Firm: _____          By: _____ Dated: _____</p>
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### Producer's Statement

I hereby certify that all the information contained in the Adoption and Participation Agreement 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 coverages to the entity.

Name \_\_\_\_\_ Taxpayer I.D. or Social Security No. \_\_\_\_\_

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

Telephone \_\_\_\_\_ E-mail \_\_\_\_\_ Insurance License no. \_\_\_\_\_ Insurance licensed attached:  Yes  No

Producer signature \_\_\_\_\_ General agent **Pearl & Associates, Ltd.**  
 Larry White Ins. Serv., Inc. GCA122042

Are you presently appointed with: Security Life  Yes  No

# Pearl Dependable Group Dental Insurance

Schedule of monthly premiums—effective 9/1/00

Employee Status	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7
Employee only	19.20	21.60	23.70	25.86	28.20	30.36	33.18
Employee + spouse	38.40	43.20	47.40	51.72	56.40	60.72	66.36
Employee + child(ren)	40.32	45.36	49.80	54.30	59.22	63.72	69.66
Employee + family	54.72	61.56	67.56	73.68	80.34	86.52	94.56

State	Area	State	Area
AK	6	MN	1
AL	2	550-554	3
AR	1	MO	1
	720-722	630-633	3
AZ	3	640-641	3
	850-853	MS	1
	856-857	390-392	2
CA	4	MT	3
	900-904	NC	1
	905-912	271-282	2
	913-916	ND	1
	917-925	NE	1
	926-951	680-681	2
	952-958	NH	4
CO	3	NJ	4
	800-809	070-076	5
	815-816	078-079	5
CT	5	NM	2
	068-069	870-875	3
DC	5	NV	3
DE	4	890-897	5
FL	3	OH	2
	320-322	440-444	4
	330-332	OK	2
	333-334	730-731	3
	340-349	740-748	3
GA	1	OR	4
	300-303	PA	2
HI	3	150-153	4
IA	1	180-181	4
	500-503	189-194	4
ID	2	RI	4
IL	3	SC	1
	600-606	SD	1
IN	2	TN	1
	460-466	370-374	2
KS	2	380-383	2
	660-666	TX	3
	670-672	750-753	4
KY	2	760-767	4
LA	1	770-777	5
	700-701	UT	1
	707-711	840-841	3
MA	4	VA	3
	017-020	220-223	5
	021-022	230-238	4
	023-027	VT	3
MD	3	WA	5
	207-212	980-984	6
ME	3	WI	2
MI	3	535-538	1
	480-483	WV	2
	484-489	WY	2
	493-495		

Employee Enrollment	Number of employees	Billed premium	Total
Employee only			
Employee + spouse			
Employee + child(ren)			
Employee + family			
Administration fee*	(Make check payable to underwriting company for your state. See below.)		
Area _____ Total remitted			

\* Monthly administration fee is based on group size:  
 5-14 employees \$10  
 15+ \$15

Administered by:



**Pearl & Associates, Ltd.**  
 1200 East Glen Avenue  
 Peoria Heights, IL 61616-5348  
 Fax (309) 688-5444  
 www.pearlins.com  
 1-800-289-8170

**Security Life Insurance Company of America of**  
 Minnetonka, MN, in these states:

AK, AZ, AR, CA, CO, DE, DC, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, MN, MI, MS, MO, MT, NC, ND, NV, NE, NM, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, WV, WI, WY

### Administration

- (a) All transactions other than installation of the Plan will be handled directly between the employer and the Administrator.
- (b) If the group becomes delinquent, the Agent will be sent a copy of the delinquency termination letter and also a reinstatement letter, should the premium be received within the allotted time.
- (c) Commissions will be paid to the licensed and appointed Agent after premiums have been received by the Administrator and appropriately applied.
- (d) Agent licensing and appointing will be handled through the Insurer. The Agent shall be required to provide the Insurer with a copy of his current insurance license.
- (e) The administrator may make some contact with each Employer to verify participation requirements. It is not the administrator's intention to restrict participation, but to make certain that all eligible employees are properly enrolled.

### Effective Date

The effective date of a participating employer unit shall be limited to the first or the fifteenth of the month. Employer Units requesting a fifteenth of the month Effective Date need to submit one and one-half month's premium as billing date is always on the first of the month. Eligibility for present Employees will be the initial Effective Date, while new hires will be on the first of the month following one month of continuous employment unless other provisions have been agreed upon between the Insurer and the Participating Employer Unit.

### Premiums

Applicable Premium Rates are guaranteed for each Participating Employer Unit for six (6) months from date of issue. Thereafter, rates are subject to change in accordance with the Master Policy.

### Group underwriting requirements

Group size & employer contributions  
 Minimum group size: 5 Employees  
 Employer contribution: 100% Employee-only premium or 50% of both employee and dependent premiums.  
 Employee participation: 100% of all eligible Employees, 50% of all eligible dependents

### Ineligible industries

Barber and beauty shops, barrooms, cocktail lounges, dental offices/labs, gyms/health clubs, massage parlors, pool halls, as well as groups where there is no employer-employee relationship and those groups where more than half of the employees are related by blood/marriage.

### Replacement sales

Groups with 10 or more insured employees and existing comparable employer-paid dental benefits may be eligible for CPT (Credit for Prior Time insured) towards the SLICA Benefit Waiting Periods detailed in the marketing material. Consult the administrator for CPT eligibility and applicable monthly premium rates.

Product not available in all states. Contact Pearl & Associates, Ltd. regarding current product approval in your state.

Pearl Dependable Group Dental Insurance Enrollment Card				Return this to Pearl & Associates, Ltd., 1200 East Glen Avenue, Peoria Heights, IL 61616-5348		For company use only	
Social Security number	Last name	First	Initial	Birth date Mo. / Day / Yr.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Effective date	
Home address <i>Name of professional association you belong to, if applicable</i>						Plan code	
City, State, ZIP			Phone	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Waiver	CPT
Name and address of employer				Hire date: Mo. / Day / Yr.		Group number	
City, State, ZIP			Phone			Division number	

List below all dependents to be covered									
Last name (if different)	First	Initial	Sex M F	Birth date Mo. / Day / Yr.	Last name (if different)	First	Initial	Sex M F	Birth date Mo. / Day / Yr.
2. Spouse					5. Child				
3. Child					6. Child				
4. Child					7. Child				

Does spouse have a dental plan?  Yes  No With whom? \_\_\_\_\_ If answer is "Yes," are dependents enrolled under Spouse's plan?  Yes  No  
 I am applying for coverage for:  Myself  Myself and eligible dependents Are all listed dependent children over age 18, full-time students?  Yes  No If "No," who isn't? \_\_\_\_\_

Underwritten by:  
 Security Life Insurance Company of America of Minnetonka, MN  
 Policy #GH-1112-92307 S10299

By my signature below, I hereby apply for coverage under group dental insurance policy GH-1112.  
 Employee's signature \_\_\_\_\_ Date \_\_\_\_\_  
 I hereby authorize payroll deductions from my earnings for any contribution required. This authorization remains in effect until revoked by me in writing.  
 Employee's signature \_\_\_\_\_ Date \_\_\_\_\_

Pearl Dependable Group Dental Insurance Enrollment Card				Return this to Pearl & Associates, Ltd., 1200 East Glen Avenue, Peoria Heights, IL 61616-5348		For company use only	
Social Security number	Last name	First	Initial	Birth date Mo. / Day / Yr.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Effective date	
Home address <i>Name of professional association you belong to, if applicable</i>						Plan code	
City, State, ZIP			Phone	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Waiver	CPT
Name and address of employer				Hire date: Mo. / Day / Yr.		Group number	
City, State, ZIP			Phone			Division number	

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Home address <i>Name of professional association you belong to, if applicable</i>						Plan code	
City, State, ZIP			Phone	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Waiver	CPT
Name and address of employer				Hire date: Mo. / Day / Yr.		Group number	
City, State, ZIP			Phone			Division number	

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Last name (if different)	First	Initial	Sex M F	Birth date Mo. / Day / Yr.	Last name (if different)	First	Initial	Sex M F	Birth date Mo. / Day / Yr.
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## Fraud Warning Statements

**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 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 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.

**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.

**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.

**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.

SLICA-000748

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SLICA-000748

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**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.

SLICA-000748

## Waiver of Coverage

I have been provided the opportunity to enroll for coverage in Pearl Dependable Group Dental. However, I decline to participate at this time as I am presently insured under another dental plan. I understand that I will only become eligible to enroll in the plan as a result of a qualifying event or during the annual open enrollment period.

Employee's signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Employer \_\_\_\_\_

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