

APPLICATION FOR DENTAL/VISION INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA

PLEASE PRINT IN BLUE INK

APPLICANT(S) INFORMATION

PROPOSED INSURED:

First Name

Middle Initial

Last Name

Birth Date: Month

Day

Year

Age

Male Female

Mailing Address:

Street (Include Apt.)

City

State

ZIP

A physical address is required if different than your mailing address. P.O. Boxes are not accepted as a physical address.

Physical Address:

Street (Include Apt.)

City

State

ZIP

Phone Numbers: ( ) Home

( ) Other

Best number and times to call

E-mail Address

DEPENDENTS: List below any dependents to be covered under the policy.

Name (Last, First, M.I.)

Relationship

Birth Date

Gender

Spouse

M F

PAYOR:

(If not You): Name

E-mail Address

Street

City

State

ZIP

- 1. Total Annual Household Income: \$15,000 or less, \$15,001 to \$35,000, \$35,001 to \$50,000, \$50,001 to \$75,000, \$75,001 to \$99,999, \$100,000 or more

Yes No

- 2. Have you or has any applicant lived in the 50 states of the USA or the District of Columbia for less than the past 12 months?
3. Do you or does any applicant now have dental insurance that will not terminate prior to the requested effective date?
4. If you are applying for vision insurance, do you or does any applicant now have vision insurance that will not terminate prior to the requested effective date?



REQUESTED EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

(See Statement of Understanding section.)

Plan Choices:  UnitedHealthcare Dental Premier<sup>SM</sup>  UnitedHealthcare Dental Value<sup>SM</sup> (if available)

OPTIONAL:  UnitedHealthcare Vision (if available)

Payment Mode:  Monthly  Quarterly  Semi-annual  Annual

Payment Options: Initial Payment with Application:  Check  EFT  Credit Card

Ongoing Payments:  Monthly EFT  Direct Bill  List Bill (include forms; \$25 monthly admin. fee per list bill group)

**STATEMENT OF UNDERSTANDING**

I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule with this application; (b) if other dental/vision insurance exists that duplicates coverage under the dental/vision plan being applied for, the existing dental/vision coverage must be terminated prior to the effective date of this coverage; (c) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (d) the policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that, for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that, for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the **postmark date** affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

By signing below, I also acknowledge that I have received a copy of the outline of coverage.

X \_\_\_\_\_ X \_\_\_\_\_ X \_\_\_\_\_  
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child State where you signed this application Date you signed and read application  
  
X \_\_\_\_\_ X \_\_\_\_\_  
Licensed Agent or Broker (Please print.) Individual Producer Number

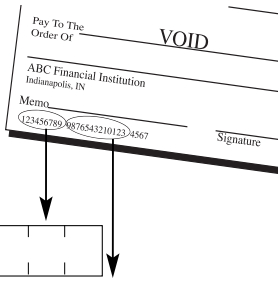
**IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. No application will be accepted if received by Golden Rule more than 15 days after the date signed. Altered applications will not be accepted.**

**CONTINUE WITH PAYMENT INFORMATION ON NEXT PAGE**

**Mail completed application to:**  
Golden Rule Insurance Company  
**DENTAL APPLICATION**  
PO Box 68994  
Indianapolis, IN 46268-0994

**ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — ONLY IF PAYING BY EFT**

I (we) hereby authorize Golden Rule to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account. I agree this authorization will remain in effect until you actually receive written notification of its termination from me.



Type of Account:  Checking  Savings

Nine-digit Routing No.

Acct No.

Financial Institution's Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Draft On \_\_\_\_\_ Day \_\_\_\_\_ Date Signed \_\_\_\_\_

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

X \_\_\_\_\_  
 Authorized Account Signature  
 E-mail Address \_\_\_\_\_

**INITIAL PAYMENT CREDIT CARD AUTHORIZATION**

I authorize Golden Rule to bill my MasterCard/Visa account for the Total Premium for Mode Chosen.\*

Type of Card:  MasterCard  Visa Exp. Date:  /   
 Month Year

Name as Printed on Card: \_\_\_\_\_

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

Card Number:   
 X \_\_\_\_\_  
 Signature of Authorized User

Note: Some card issuers/financial institutions charge cash advance fees on insurance payments.

**CALCULATE YOUR PREMIUM**

**1 TEXAS DENTAL BASE RATES**

UnitedHealthcare <i>Dental Premier</i>	1 Person	2 People	3+ People
Statewide	31.71	62.79	110.99
UnitedHealthcare <i>Dental Value</i>			
ZIP Codes 750-753, 760-762, 770-777, 780-782, 786, 787	20.73	41.05	72.56

**2 TREND FACTORS**

Effective Dates	Factor
January through March 2009	1.015
April through June 2009	1.030
July through September 2009	1.045
October through December 2009	1.060

**3 TEXAS VISION RATES**

Statewide	9.00	16.00	24.00
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**4 PAYMENT MODE FACTORS**

Modes	Factor
Monthly	1
Quarterly	3
Semi-annual	6
Annual	12

**PREMIUM CALCULATION**

1 Dental Base Rate for Plan Chosen	_____
2 Trend Factor	x _____
3 Subtotal	= _____
4 Vision Rate	+ _____
5 Subtotal	= _____
6 Payment Mode Factor	x _____
<b>Premium for Mode Chosen*</b>	= <input type="text"/>

\*The amount charged to your credit card will be the total amount for the payment mode chosen (Monthly, Quarterly, Semi-annual, or Annual).

# Outline of Coverage for Policy Form GRI-DEN1-42

**Read Your Policy Carefully** -- This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail your and our rights and obligations. For this reason, It is important that you READ YOUR POLICY CAREFULLY!

**Dental Coverage** – Plans of this type are designed to provide the covered persons with coverage for dental care. The cost must be due to a covered dental service. Coverage is provided for preventive, basic, and major dental services. Coverage is subject to any deductible amounts, coinsurance amounts, or other limitations that may be set forth in the policy.

## DENTAL BENEFITS

Benefits are limited to the dental services described below, but only when each service is a covered expense:

- (A) Oral evaluations (periodic, comprehensive and problem focused) payable twice in any calendar year;
- (B) Prophylaxis or cleaning teeth, payable twice in any calendar year;
- (C) Topical fluoride for a covered person who is not yet age 16, payable twice in any calendar year. Topical fluoride treatment should be done in conjunction with dental prophylaxis;
- (D) Full mouth (which includes bitewings) or panorex X-rays, payable once every 36 months. An exception will be made to the 36 month limit if the full mouth or panorex X-rays are for diagnosis of third molars, cysts, or neoplasm;
- (E) Up to four bitewing X-rays, payable once in any calendar year;
- (F) Periapical X-rays;
- (G) Sealants or preventive resin restorations, limited to once per first or second permanent molar every 36 consecutive months, for a covered person who is not yet age 16;
- (H) Simple (non-surgical) extractions;
- (I) Injection of antibiotic drugs at the time of initial treatment;
- (J) Palliative treatment when no other service, other than X-rays and exam, was done on the same tooth during the same visit;
- (K) Emergency palliative treatment for dental pain;
- (L) Amalgam fillings and direct resin fillings. Multiple restorations on one surface will be treated as a single filling;
- (M) Analgesia, for a covered person who is not yet age 13;
- (N) Sedative fillings as a separate benefit when no other service, other than X-rays and exam, was done on the same tooth during the same visit;
- (O) Stainless steel crowns on primary teeth;
- (P) Space maintainers to maintain space because of prematurely lost primary teeth, including the cost of recementing limited to once per lifetime, for a covered person who is not yet age 16. This includes all adjustments within 6 months of installation;
- (Q) Repair or recementing of crowns, inlays, onlays, veneers, bridgework, or dentures, relines and rebases, but not within 6 months of the initial placement and not more than once in any 12 month period;

- (R) Endodontic treatment, including root canals, pulpotomies on primary teeth and apicoectomy. To be a covered expense, pulpotomies performed on permanent teeth must be combined with the completed root canal;
- (S) Periodontics, including procedures necessary for treatment of disease of the gums and bone supporting teeth. Periodontal maintenance and gingival inflammation cleaning procedures are covered as routine prophylaxis benefits under preventive services if no active therapy has been performed. Active periodontal therapy means periodontal surgical or non-surgical treatment. Periodontal maintenance procedures are payable twice in any calendar year. Periodontal root planing and scaling is payable every 24 month period, limited to four quadrants. Full mouth debridement is limited to once every 36 consecutive months. The benefit for periodontal surgery includes three months of post-surgical care. Any periodontal surgery performed in the same quadrant within 36 consecutive months after the initial surgery was performed is not payable. If more than one surgical service is performed on the same day, only the most inclusive surgical service performed will be considered a covered expense;
- (T) Osseous grafts with or without restorable or non-restorable GTR membrane replacement are limited to once every consecutive 36 months per quadrant or surgical site;
- (U) Pin retention, limited to 2 pins per tooth; this is not a covered expense if pin retention is in addition to cast restoration. (Cast restoration is defined as crowns, inlays and onlays.);
- (V) Inlays, onlays, or veneers limited to one time per 60 consecutive months;
- (W) Core buildup, cast and prefabricated post and core. Posts and cores are covered expenses only for teeth that have had a root canal therapy;
- (X) First installation of bridgework to replace one or more functioning natural teeth lost while you or your covered dependents are insured by this plan. This includes inlays and crowns as abutments;
- (Y) Full or partial dentures or overdentures, payable once every 5 years. The amount we will pay for overdentures will not exceed the benefit we would pay for full dentures;
- (Z) Oral surgery, including surgical extractions and removal of impacted teeth. Charges for diagnostic X-rays must be included in the charges for oral surgery to be covered expenses; and
- (AA) General anesthesia, but only: For removal of impacted teeth;
  - (1) For removal of seven or more teeth; or
  - (2) If dentally necessary in conjunction with complex oral surgery.

For all covered expenses, the following dental services will be considered part of the entire dental service and not eligible for benefits as a separate service: cement bases; pulp caps; study models/diagnostic casts; acid etch; bonding agents; and local anesthetic.

## AMOUNT PAYABLE

We will pay the coinsurance percentage in excess of the deductible amount for services and supplies that qualify as covered expenses and are received while the covered person's coverage is in force under the policy.

**The Deductible Amount:** "Deductible amount" means the amount of covered expenses shown in the Data Page that must be actually paid by each covered person during any calendar year before any benefits are payable.

A new deductible must be met each calendar year.

**Coinsurance Percentage:** "Coinsurance percentage" means the percentage of covered expenses that are payable by us.

"Out-of-pocket expenses" means those expenses that a covered person is required to pay that qualify as covered expenses and are not paid or payable if a claim were made under any other plan.

**Maximum Benefit:** The maximum benefit per covered person, per calendar year is shown in the policy Data Page.

**Waiting Period:** "Waiting Period" means a period of time for which a covered person must wait, after the effective date of coverage, before dental services listed in Section 8: Dental Benefits will be covered.

Benefits for certain types of dental services will not be payable until after a waiting period as shown in the Data Page has been satisfied.

## WHAT IS NOT COVERED

No benefits will be paid for any services not identified and included as covered expenses under the policy. You will be fully responsible for payment for any services which are not covered expenses.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred for:

- (A) Any expense or service related to that expense:
  - (1) That is not a covered expense;
  - (2) Incurred during the waiting period;
  - (3) To the extent that expense exceeds: (a) The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a contracted provider, if Section 2, Data Page, of this policy identifies your plan choice as Dental Value; or (b) The reasonable and customary charge for that expense, if Section 2, Data Page, of this policy identifies your plan choice as Dental Premier.
- (4) For which no benefit is described in the policy or in the Data Page;
- (5) For a dental service that is not rendered or that is not rendered within the scope of the dentist's license;
- (6) For dental services, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for under the Dental Benefits provision of this policy;
- (7) Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service;
- (8) For telephone consultations or for failure to keep a scheduled appointment;

- (9) For any dental service incurred directly or indirectly as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor;
- (10) For or while receiving investigational treatment or for complications there from, including expenses that might otherwise be covered if they were not incurred in conjunction with, as a result of, or while receiving investigational treatment;
- (11) As a result of dental services arising out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law; or
- (12) As a result of: (a) Intentionally self-inflicted bodily harm (whether the covered person is sane or insane); (b) Dental services necessitated due to participation in any act of declared or undeclared war; (c) The covered person participating in a riot; or (d) The covered person's commission of a felony, whether or not charged.
- (B) Any dental service:
- (1) Provided by a government plan, program, hospital or other facility, unless by law you or your covered dependent must pay and it is otherwise a covered expense;
  - (2) Which by law must be provided by an educational institution;
  - (3) Which we are not legally obligated to pay, unless provided by Medicaid or by the Veteran's Administration for non-service related dental services and which by law we are required to pay;
  - (4) Provided prior to the effective date or after the termination date of this policy;
  - (5) Received outside of the United States, except for a dental emergency;
  - (6) For jaw-joint problems, including but not limited to: temporomandibular or craniomandibular joint dysfunction, myofunctional therapy, physical therapy;
  - (7) Relating to: teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by us;
  - (8) That is considered cosmetic dentistry, including, but not limited to: porcelain on a crown, abutment or pontics posterior to the second bicuspid; personalization or characterization of prosthetic devices; or composite restorations on molar and/or bicuspid teeth. Alternate services will be applied allowing benefits for amalgam restoration; bleaching; and services done to alter the shape or size of teeth. (Cosmetic services are those services that improve physical appearance);
- (C) Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction;
- (D) Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation;
- (E) Orthognathic surgery to correct malposition of jaw bones;
- (F) Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue;
- (G) Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal;
- (H) Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function;
- (I) Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; replacement of orthodontic retainers; treatment splints; bruxism appliance; sleep disorder appliance; and gold foil restorations;
- (J) Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; prescription and non-prescriptions drugs, with or without a prescription, unless they are dispensed and utilized in the dental office during your or your covered dependents dental visit, except we will pay for injection of antibiotic drugs at the time of initial treatment; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures;
- (K) Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are:
- (1) Congenitally missing; or
  - (2) Lost before insurance under this policy is in effect;
- However, benefits are available for covered expenses for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first 6 months following the date of placement, only if:
- (1) The teeth were lost while the covered person was under the policy and the initial placement is within 12 months of the date of loss of the teeth; or
  - (2) The extraction took place while the covered person was both under age 16 and insured under this policy;
- (L) Replacement within 60 consecutive months of the last placement for full and partial dentures and replacement within 60 consecutive months of the last placement for crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge or denture is installed within 12 months from the date the temporary service was installed;
- (M) Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances inserted prior to plan coverage unless the covered person has been insured under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, dental services associated with the addition will be covered when the service is a covered expense;
- (N) Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of your or your dependents' non-compliance, you are liable for the cost of the replacement;
- (O) Dental implants and any related procedures, including but not limited to crowns, bridges, and dentures;
- (P) Hospital or other facility charges and related anesthesia charges;
- (Q) Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis;
- (R) Local anesthetic; analgesia; and behavior management and conscious sedation;
- (S) Charges for dental services that are not documented in the dentist records, not directly associated with dental disease or not performed in a dental setting ;
- (T) Orthodontia;
- (U) Acupuncture; acupressure and other forms of alternative treatment;
- (V) Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations); or
- (W) Any dental services for which benefits are payable under a medical policy issued by us.

#### Exclusion on charges in excess of reasonable and customary:

If a charge incurred by you or your covered dependent for services or supplies is in excess of the reasonable and customary charge, no payment will be made with respect to the excess amount of the charge. That part of the charge that is in excess of the reasonable and customary charge will not qualify as a covered expense under this policy.

#### TERM OF COVERAGE AND RENEWABILITY

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

#### Dental claims incurred prior to a termination date:

Termination of insurance or termination of a benefit will not apply to a valid claim for benefits incurred before the termination date.