



**POWERFUL DENTAL CARE WHERE AND WHEN YOU NEED IT.**

**Voluntary and  
75% Participation  
Dental Plans  
for Groups 2 - 125**

Choose any Dentist

...

No Waiting Periods

*Insured by:*

**Pan American Life Insurance**



## Voluntary and 75% Participation Group Dental Plans

### Covered Services

This Plan reimburses you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those covered expenses to a calendar year maximum of \$1000 for the first year, \$1250 for the second year, and \$1500 for the third and following years. These percentages are: 100% for Class I, 80% for Class II and 25% for Class III in the first year. In the second year of coverage, Class III reimbursement increases to 50% of the R&C rate.

Magnum Dental allows you to select your own dentist and it provides affordable rates guaranteed for 12 months.

#### Class I - Preventive Services

- Two exams per year
- Two cleanings per year
- One topical fluoride per year *to age 16*
- One series of bitewing x-rays per year

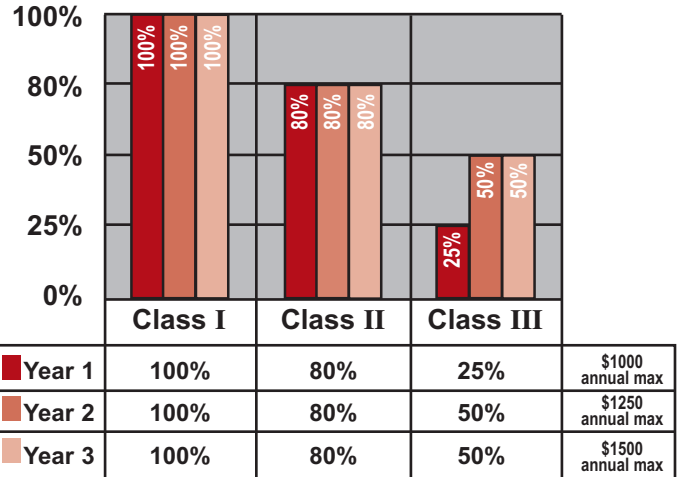
#### Class II - Basic Services

- Basic fillings
- Space maintainers
- Sealants (*children to age 16*)

#### Class III - Major Services

- Simple extractions
- Oral surgery
- Endodontic treatment
- Periodontic services
- Crowns, inlays and onlays
- Prosthetic services; bridges and dentures
- One diagnostic x-ray, full or panoramic in any 3 year period
- Implants (endosteal only), up to the allowance for the lowest cost covered traditional procedure

**Credit for Prior Time (CPT)** - If you currently have existing group coverage, then takeover credit is available for the amount of time covered under the prior plan. Any waiting satisfied under the prior plan is credited to the new plan. CPT does not apply to annual maximums.



**Participation Requirements** - Not less than two employees (75% of the employer's eligible employees - the greater number after waivers) must be enrolled in the 75% Participation plan. For the Voluntary plan, not less than two employees must enroll. 100% family-related employees may apply for a 10% rate increase.

**\$100 Lifetime Deductible** - Applies to preventive, basic, or major services per person.

**Optional Orthodontic Services** are available for additional premium for employers with 2 enrolled or more. Orthodontic care for the proper alignment of teeth is provided to children and adults. Coverage is reimbursed 25% first year and 50% reimbursed for the second year, with a lifetime maximum benefit of \$1200 per person.

**Optional \$50/\$150 Annual Deductible** - You may choose to replace the \$100 lifetime deductible for a \$50/ \$150 calendar year deductible per person/ family that applies to Class II and III services for a 12% rate increase.

**Optional Endo/Perio to Class II** - You may choose to have Endodontics and Periodontics covered under Class II services for a 10% rate increase for employers with 5 enrolled or more.

Insured By:



Plan Coordinator:

Direct Benefits, Inc.  
325 Cedar Street, Suite 800  
Saint Paul, MN 55101  
651.649.3503 • 800.620.5010

Distributed by:



# 75% PARTICIPATION GROUP DENTAL PLAN



## 2 - 4 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
Employee	\$21.96	\$24.67	\$27.11	\$28.47	\$29.55	\$32.27	\$34.71	\$37.96	\$43.38
Employee +1	\$42.04	\$47.23	\$51.90	\$54.50	\$56.57	\$61.76	\$66.43	\$72.66	\$83.04
Family	\$70.59	\$79.30	\$87.15	\$91.50	\$94.99	\$103.70	\$111.55	\$122.01	\$139.43

## 5 - 125 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
Employee	\$19.10	\$21.46	\$23.58	\$24.76	\$25.70	\$28.06	\$30.18	\$33.01	\$37.72
Employee +1	\$36.56	\$41.07	\$45.13	\$47.39	\$49.19	\$53.71	\$57.77	\$63.18	\$72.21
Family	\$61.38	\$68.96	\$75.78	\$79.57	\$82.60	\$90.18	\$97.00	\$106.09	\$121.25

# VOLUNTARY GROUP DENTAL PLAN

## 2 - 4 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
Employee	\$24.16	\$27.14	\$29.83	\$31.32	\$32.51	\$35.49	\$38.18	\$41.76	\$47.72
Employee +1	\$46.24	\$51.95	\$57.09	\$59.95	\$62.23	\$67.94	\$73.08	\$79.93	\$91.35
Family	\$77.65	\$87.23	\$95.86	\$100.65	\$104.49	\$114.07	\$122.70	\$134.21	\$153.38

## 5 - 125 LIVES

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
Employee	\$21.01	\$23.60	\$25.94	\$27.23	\$28.27	\$30.86	\$33.20	\$36.31	\$41.50
Employee +1	\$40.21	\$45.18	\$49.65	\$52.13	\$54.11	\$59.08	\$63.55	\$69.50	\$79.43
Family	\$67.52	\$75.86	\$83.36	\$87.53	\$90.86	\$99.20	\$106.70	\$116.70	\$133.37

Rate Effective Dates 5/1/2006 - 7/31/2008

## PLAN OPTIONS

### ORTHODONTIA RATES (\$1200 lifetime maximum for adults and children)

Orthodontia can be added to any of the above plans by adding these premiums to the selected rate above. Orthodontia is covered at 25% first year and 50% second year with a \$600 annual maximum benefit per person.

	Employee	Employee +1	Family
2-125 lives	\$3.17	\$6.06	\$10.17

### ENDO/PERIO TO BASIC (Class II)

Minimum of 5 enrolled employees.  
Multiply rates by 1.10.

### \$50 ANNUAL DEDUCTIBLE (CLASS II & III). Multiply rates by 1.12.

**NOTE: A \$15 monthly administration fee will be added to each employer group. \$15 fee is waived if employer is paying by ACH bankdraft.**

## MAGNUM DENTAL NEW JERSEY AREA FACTORS

New Jersey	
All others	4
070	4
074-076	5
078-079	5
088-089	5

# EMPLOYER APPLICATION FOR GROUP MAGNUM DENTAL INSURANCE

The Employer hereby requests to insure eligible persons under Policy DEN-06-P, Magnum, based upon its statements and representations that follow. The Employer must select the coverage and pay the required premium. Those eligible will be covered as described in this application. It is agreed that this application supersedes any previous application for this Group Dental Insurance.

Employer Name: \_\_\_\_\_ Employer Tax ID Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone number: ( ) \_\_\_\_\_ Direct Communications To: \_\_\_\_\_  
(Name and Title)

Fax number: ( ) \_\_\_\_\_ Contact email address: \_\_\_\_\_

Description of Business: \_\_\_\_\_  
 Corporation  Partnership  Sole Proprietorship  Other

Subsidiaries and Affiliates Included:  Yes  No Affiliate Name(s): \_\_\_\_\_

## **PROVISION AND BENEFIT SELECTION**

**Effective Date of Employer Participation:** \_\_\_\_\_ (not sooner than the first day of the first month following acceptance by the Company).

### **75% PARTICIPATION**

2-4 Employees  5 or more Employees ("5+")

#### Coverage Options\*:

- 2+ Orthodontia, if available in your state  
(\$3.17, employee. \$6.06, employee +1. \$10.17, family)  
 5+ Endo/Perio covered under Class II (premium x 1.10)  
 \$50 annual deductible for Class II & III (premium x 1.12)

### **EMPLOYER VOLUNTARY**

2-4 Employees  5 or more Employees ("5+")

#### Coverage Options\*:

- 2+ Orthodontia, if available in your state  
(\$3.17, employee. \$6.06, employee +1. \$10.17, family)  
 5+ Endo/Perio covered under Class II (premium x 1.10)  
 \$50 annual deductible for Class II & III (premium x 1.12)

\* **Premiums must be adjusted accordingly**

### **Take Over Benefit Coverage**

#### Class of Employees:

Regular full-time Employees working 20 or more hours per week.

- All Employees  
 All regular full-time Employees  
 All Employees, except \_\_\_\_\_

Employees must be actively at work on Effective Date of coverage, if not, coverage will be effective on the First day of the month following return to active employment.

Copy of Prior Dental Plan's Schedule of Benefits  Yes  No

Copy of Prior Dental Plan's Last Billing Statement  Yes  No

#### Employee Waiting Period:

Waiting Period (current Employees):  Effective Date  2 months  other \_\_\_\_\_  
 1 month  3 months  
Waiting Period (new Employees):  1 month  2 months  
 3 months  date employed  other \_\_\_\_\_

New Employees are covered on the first day of the month following the Waiting Period.

#### Indemnity Premiums :

Employee: \$ \_\_\_\_\_ Employee/One Dependent: \$ \_\_\_\_\_ Employee/Family: \$ \_\_\_\_\_

#### DHA-Premier Premiums :

Employee: \$ \_\_\_\_\_ Employee/One Dependent: \$ \_\_\_\_\_ Employee/Family: \$ \_\_\_\_\_

## **BEFORE YOU SIGN, PLEASE SEE THE BACK OF THIS DOCUMENT FOR IMPORTANT FRAUD NOTICES**

Employer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Name Title

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Name State License #

**PAN-AMERICA LIFE INSURANCE COMPANY**  
**New Orleans, Louisiana**

**Magnum Dental Employee Enrollment Form**

**Employer Information (TO BE COMPLETED BY THE EMPLOYER)**

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

**Employee Information (PLEASE PRINT CLEARLY)**

Last Name	First Name	Initial	Birth Date ____/____/____	Marital Status
Address	Telephone Number	Sex M [ ] F [ ]		Married [ ] Single [ ]
City	State	Zip	SS #	

**FAMILY INFORMATION (List only those eligible family members who are enrolling)**

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

**COVERAGE SELECTION:\***  Dental Coverage  I Do Not Want Dental Coverage and Waive My Right To It

I apply for coverage on:  Employee Only  Employee + One  Employee and Family

- 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 listed above over age 18 are full-time students. Yes  No

\*Group Dental Coverage is provided under the Group Dental Insurance Policy issued to the Group Policyholder insured by Pan-American Life Insurance Company. If applicable, your Employer may have selected Orthodontia, Endo/Perio, and Annual Deductible options. You cannot receive these benefit options unless your Employer has selected them.

**By my signature below, I hereby apply for the coverage or coverages selected above. If I am waiving coverage, I have checked the box "I Do Not Want Dental Coverage and Waive My Right To It." I CERTIFY THAT I HAVE READ THE APPLICABLE FRAUD NOTICE ON THE REVERSE SIDE. 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

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

**Mail To:**  
**Direct Benefits, Inc.**  
**325 Cedar Street, Suite 800**  
**Saint Paul, MN 55101**  
**800.620.5010**

**Administered by:**  
**Meritain Health**  
**P.O. Box 27810**  
**Minneapolis, MN 55427-0810**  
**(800)-765-4224 (952) 541-0444**



## IMPORTANT FRAUD NOTICES

### **FRAUD STATEMENT**

Any person who knowingly and with the 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.

### **FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA**

Any person who knowingly presents a false or fraudulent claim for payment of 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.

### **FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

### **FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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 benefit if false information materially related to a claim was provided by the applicant.

### **FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA**

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

### **FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

### **FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO**

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

### **FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA**

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

### **FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS**

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

### **FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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.

### **FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA**

Any person who, with the 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 may have violated state law.



**Authorization to honor checks drawn or automatic debit entries made by  
Meritain Health  
400 Highway 169 South, Suite 800  
Minneapolis, MN 55426-1141**

**Name of bank:** \_\_\_\_\_  
(Include branch name if applicable)

**Address of bank/branch:** \_\_\_\_\_

**Bank routing number:** \_\_\_\_\_ **Account number:** \_\_\_\_\_

**Account type:**  **Checking** (please attach a voided check)  **Savings**

**Print name of bank depositor/account holder:** \_\_\_\_\_

**For the purpose of paying premiums on the policies or contracts listed below:**

**Policy or contract no.:** \_\_\_\_\_

**Name of insured:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Indemnification agreement**

**To the bank named above:**

In consideration of your participation in the arrangement authorized by your depositor in this document hereof, whereby amounts payable to this company are collected by checks drawn or automatic debit entries made by the company on the account of the depositor, Meritain Health hereby agrees:

- 1) Meritain Health will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn or automatic debit entry made by Meritain Health on the account of such person, or arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such check drawn or automatic debit entry made by Meritain Health, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy or contract of insurance, the premium on which is sought to be collected by Meritain Health, by any such check or automatic debit entry, and
- 2) Meritain Health will refund to you any amount erroneously paid by you on any such check or automatic debit entry if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check or automatic debit entry on which such erroneous payment was made.

If your participation in this arrangement is to be terminated, the company requests 30 days written notice to be sent to its Executive Office, 400 Highway 169 South, Suite 800, Minneapolis, MN 55426-1141.

Vice President Claims

**Bank depositor/Account holder authorization**

**I hereby authorize** Meritain Health to draw checks or make withdrawals by automatic debit each month on this account. Funds will be withdrawn on the policy or contract due date.

**I agree** that the presentation of such check or automatic debit to such bank shall constitute due notice of premium being due upon the said policies or contracts.

**I agree** that if any withdrawal for the payment of premiums is dishonored, or if the amount has been refunded to the bank upon its request, the payment shall be considered to be in default and if payment of the premium in default is not made within 31 days of the date on which such premium was due, the policy or contract shall terminate except as may otherwise be provided therein.

**I agree** that this arrangement may be discontinued by either of us for any reason at any time upon written notice to the other. On or after such discontinuance, premiums shall be payable as provided in the policy or contract and at the company's rate for the method of payment selected.

**I hereby authorize** the bank listed above to honor and charge to my account checks drawn or automatic debit entries made on my account by and payable to Meritain Health. The signatures on such checks may either be typed or printed. The bank shall have no liability for the return unpaid of any such check or automatic debit entry if the balance in my account is insufficient to pay the same upon presentation. I further agree that if any such check or automatic debit entry be dishonored, the bank shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization shall continue in force until revoked by me in writing.

\_\_\_\_\_  
(Signature of Bank Depositor/Account Holder)

\_\_\_\_\_  
(Date)



## NEW BUSINESS CHECKLIST

Please confirm that the following is submitted with all new cases.

- Completed Employer Application
- Completed Employee Enrollments
- First Month Premium (payable to Pan American Life Insurance)
- \$10 monthly administration fee. \$10 fee is waived if paying by ACH bankdraft
- Producer Licensing Forms (if not previously contracted)

### TAKE OVER BENEFIT COVERAGE

Please confirm that all of the following documentation is provided prior to coverage on take over cases:

- Copy of Prior Carrier's certificate, booklet or schedule of benefits
- Copy of Prior Carrier's most recent billing statement

After all of the information listed above is completed and signed send all original forms to:

**Direct Benefits, Inc.**  
**325 Cedar Street, Suite 800**  
**Saint Paul, MN 55101**  
**651.649.3503 • 800.620.5010**

### Submission Date:

New Group Information should be postmarked no later than the end of the month to be effective by the first of the following month.