

MEMBER APPLICANT

LAST NAME _____
FIRST NAME _____ M.I. _____
SOCIAL SECURITY NUMBER _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE NUMBER () _____
BIRTHDATE ___/___/___ Age ___ Sex... Male Female
MARITAL STATUS..... Single Married
EMAIL _____

COVERAGE

Requested effective date ___/___/___
Plan Name Elected _____

DEPENDENT INFORMATION

Spouse's Name _____
Date of Birth _____ Age ___ Sex ___
SSN # _____ Occupation _____
Child's Name _____ Sex _____
Date of Birth _____ Student (over age 19*)... Yes No
Child's Name _____ Sex _____
Date of Birth _____ Student (over age 19*)... Yes No
Child's Name _____ Sex _____
Date of Birth _____ Student (over age 19*)... Yes No
Child's Name _____ Sex _____
Date of Birth _____ Student (over age 19*)... Yes No

* Not applicable in IN, TN, TX and UT

Will you or any dependent have other dental insurance coverage?

..... Yes No

If yes, please list the name of the other insurance company and phone number: _____

ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the Standard Security Life Insurance Company of New York group plan offered by the Group. I reserve the right to revoke or change this authorization by written notice. I represent that the information provided is true and complete to the best of my knowledge and belief.

Date _____ City _____ State _____

Signature of Member Applicant _____

FRAUD WARNING STATEMENTS

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

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

Agent Use Only: Are you currently appointed with Standard Security Life Insurance Company of New York? Yes No

Agent Name _____ HPA # _____

Phone _____ E-mail _____

Agent Signature _____

Address _____

City _____ State _____ Zip _____

GA Name _____ # _____

MGA Name Insurance Services of America, Inc. # 450000000

Secure DentalOne Rate Calculation Chart (CA)
Underwritten by Standard Security Life Insurance Company of New York

ZIP CODE AND AREA RATE FACTOR CHART

Alabama	0.81	Minnesota	0.91
Alaska	1.60	554	1.09
Arizona	0.91	550-553, 555	1.00
850-853	1.00	Mississippi	0.81
Arkansas	0.81	Missouri	0.81
California	1.09	630-634, 640-641	0.91
900-904	1.28	Montana*	
905-916, 926-931	1.19	Nebraska	0.81
940-944	1.28	New Hampshire	1.09
945-951	1.19	Nevada	1.09
Colorado	1.00	893-898	1.19
800-804	1.09	New Mexico	0.91
808-809	1.09	North Carolina**	0.91
Connecticut	1.19	275-277	1.00
068-069	1.28	282	1.09
Delaware	1.19	North Dakota	0.81
Dist of Columbia	1.19	Ohio	0.81
Florida	1.00	430-432, 434-436	0.91
330, 332-334, 340	1.09	439-445, 450-452	0.91
331	1.19	456	0.91
Georgia	0.91	Oklahoma	0.81
301-302	1.00	730-731, 740-741	0.91
300, 303, 311	1.09	Oregon	1.00
Hawaii	1.09	970-975	1.09
Idaho	0.81	Pennsylvania	0.91
83837	1.00	190-191	1.09
Illinois	0.81	189, 192-194	1.09
600-608	1.09	Rhode Island	1.00
610-619	0.91	South Carolina	0.91
Indiana	0.81	South Dakota	0.81
460-466, 469, 473	0.91	Tennessee	0.81
Iowa	0.91	370-372, 380-384	0.91
Kansas	0.81	Texas	0.81
660-661	0.91	762-764, 768-769	0.91
662-663	0.81	788, 790-799	0.91
664-666	0.91	750, 751, 760, 761	1.00
667-671	0.81	770, 772-777, 786	1.00
672	0.91	787, 789, 752-753	1.00
673-679	0.81	Utah	1.00
Kentucky	0.81	Virginia	
Louisiana	0.81	201	1.19
700-701, 707-712	0.91	220-223	1.09
Maine	1.00	224-232, 238-246	0.91
Maryland*		233-237	1.00
Massachusetts	1.09	West Virginia	0.81
017-019	1.19	Wisconsin	0.91
021-022	1.28	532-534, 537	1.00
Michigan	0.91	Wyoming	0.81
480-485	1.00		

SDO Zip Areas 6-08

Secure DentalOne Rate Chart

	BasicOne**	ClassicOne	PremierOne
Type of Coverage	NA	\$750	\$1250
Single	7.54	24.32	29.50
Single + 1	14.22	45.87	55.64
Single + 2	18.56	59.87	72.63
Single + 3	22.91	73.90	89.65
Single + 4	27.26	87.93	106.67
Single + 5	31.61	101.96	123.69
Single + 6 or more	35.95	115.96	140.67

**BasicOne plan not available in North Carolina.

CALCULATE YOUR COST

- Based on the plan desired and people to be insured. Enter your monthly rate. \$ _____
 - Locate your state and zip code prefix. Enter the factor. _____
 - Multiply the rate by the factor. x \$ _____
 - Add the Optional OrthoCare Discount Program*
Individual + \$ 5.00
Individual +1 or more + \$ 8.00
 - Add the monthly administration fee. + \$ 5.00
- Subtotal** \$ _____
- Multiply by number of months
[_____(months) x \$_____(subtotal) =] + \$ _____
 - Add the **ONE-TIME** enrollment fee + \$ 20.00
- Total Due** \$ _____

*OrthoCare option not available in all states.

Use state specific application for CA, CT, FL, ME.

PAYMENT METHOD

Select your payment method:

- Automatic bank draft Checking Savings

Payer name or Depositor if different _____

Relationship to applicant _____

Signature _____ Date _____

Name of financial institution: _____

Routing # _____

Account # _____

Street or PO Box of financial institution _____

City _____

State _____ Zip _____

Credit Card: VISA MASTER CARD DISCOVER

Name on Account _____

Account # _____

Expiration _____

Verify Account # _____

I hereby authorize the premiums and fees to be deducted from my bank account or credit card as indicated above and remitted to HPA, Inc. on a frequency basis as indicated above. I further authorize the bank or credit card to pay and charge my account those payments that are drawn on my account by HPA, Inc. and I agree that the bank or credit card named shall be fully protected in honoring any such payments. The bank's rights or credit card's rights and treatment of each payment shall be the same if it were signed by me. If any such payment is dishonored, with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorization remains in effect until the bank or credit card is notified by me in writing. To terminate coverage I will also notify HPA, Inc. the administrator in writing. I further hereby enroll in the CA Association and understand participation is mandatory.

Applicant Signature _____ Date _____

Make checks payable to: HPA, Inc.

Mail application to: HPA, Inc.,

P.O. Box 15250 Rockford, IL 61132-5250

Save time and postage when paying by credit card, fax your completed application toll free to:
1-815-633-0277