

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 Civil Union
 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

The following states require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state as indicated below. If your state is not listed read the last statement marked "All Other States."
Residents of 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 crime and may be subject to fines and or confinement in prison.
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.
Residents of District of Columbia- 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.
Residents of 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.
Residents of 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.
Residents of Maine- It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **NOTICE TO BUYER: THIS IS AN APPLICATION FOR DENTAL INSURANCE ONLY. READ YOUR CERTIFICATE CAREFULLY.**
Residents of 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.
Residents of 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.
Residents of Oklahoma- 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.
Residents of 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.
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.
Residents of Virginia- Any person who, with intent to defraud or knowing that he/she 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.
Residents of West Virginia- 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.
All Other States- 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.

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 (CT)
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