GEMSTAR℠ 1500

dental, vision and life insurance sales kit

Good through December 31, 2014

BROUGHT TO YOU BY:

Agent Name

Phone Number | Email Address
Website

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

BROCHURE

RATES

EMPLOYER ELECTION

EMPLOYEE ENROLLMENT

GEMSTAR℠ 1500

Dental Insurance for employer groups with 2+ lives

- Option available to receive Credit for Prior Coverage
- Rate discount for combined dental and vision package
- Dental rate discount for 50% voluntary participation
- Option of Employer Funded or Voluntary contribution
- Freedom to use any Dentist – Network Options Available for Additional Savings

Class A - Preventive	1500
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (under age 16)	
Benefit Day 1	100%
Deductible—Lifetime per Insured	$50
Waiting Period	None
Class B - Basic	
X-rays, Fillings, Simple Extractions, Sealants (under age 16)	
Benefit Day 1	50%
Benefit After Year 1	60%
Benefit After Year 2	80%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	None
Class C - Major	
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures	
Benefit Day 1	30%
Benefit After Year 1	50%
Deductible—Each Calendar Year per Insured*	$50/Year
Waiting Period	None
Class D - Orthodontics	
Straightening of Teeth (for children under age 19)	
Benefit Day 1	0%
Benefit After Year 1	50%
Deductible	None
Waiting Period	12 Months
Calendar Year Maximums	
Calendar Year Maximum for Classes A, B and C Combined	$1,500
Calendar Year Maximum for Class C – Major Services	$750
Calendar Year Maximum for Class D	$500
Lifetime Maximum Per Child for Class D	$1,000

*Class B & C Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.

PROUDLY BROUGHT TO YOU BY:

MAXIMUM CARE NETWORK

GemStar 1500 gives you the freedom to use any dentist with the advantage of utilizing a MaxCare network provider for additional savings. The MaxCare network gives you:

- Over 200,000 access points nationwide
- Discounts of 5-50% on dental services
- Network discounts available immediately
- Provider search at **Careington.com/co/SLICA**

Additionally, when you utilize a MaxCare dental provider, your out-of-pocket costs may be lower because they have agreed to a negotiated fee for services. You are responsible for any coinsurance and the required deductible. It is important to note that if you receive care from a non-MaxCare provider your out-of-pocket charges will be based on the Reasonable and Customary charge.

Not available in ID, NJ, VT, WA.

CREDIT FOR PRIOR COVERAGE

A group with current dental coverage may choose to purchase the option to receive Credit for Prior Coverage (CPC) toward satisfaction of any waiting period or graded benefit year co-insurance. Credit may be given for the length of time an employee was covered under the employer's prior dental Insurance plan, provided there is no interruption in coverage between the prior plan and the replacement plan. The prior coverage must be similar in plan design to receive CPC. For example, if the prior plan did not cover Class C - Major services, CPC is not applied to Major services.

Employer Paid plans: CPC is given at the group level based on the length of time the employer carried the previous coverage. In order to receive CPC the employee must have been covered by the employer's previous plan. Any new employee and/or dependents added subsequent to the group's effective date of this coverage will not receive CPC.

Voluntary Plans: CPC is given individually to each person (employee, spouse or child) covered. Any new employee and/or dependents added subsequent to the group's effective date of this coverage will not receive CPC.

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DENTAL EXPENSES NOT COVERED

- for overdentures and associated procedures;
- for charges in excess of those considered Reasonable and Customary;
- for cosmetic procedures;
- for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
- for implants and for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication;
- for missing tooth: when covered under your plan, benefits are provided for placement of dentures, fixed bridgework, implants or the addition of teeth to existing dentures only when the service includes replacement of a natural tooth extracted or lost while covered under this plan. This limitation ends after the individual receiving care has been covered under this plan for 36 consecutive months.
- for oral hygiene instructions; and for: plaque control, completion of a claim form acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs;
- for services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us;
- for procedures that are begun, but not completed;
- for services and treatment provided without charge, or for which there would be no charge in the absence of insurance;
- 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 a condition covered under any Worker's Compensation Act or similar law;
- for services 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 included within Coverage Schedule;
- for services rendered prior to the date the Insured is covered under the Policy;
- for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD);
- for hospital services;
- if You voluntarily end Your insurance You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended;
- charges for infection control, sterilization, and waste disposal.

UNDERWRITING GUIDELINES

ELIGIBLE EMPLOYEES

An individual employed by a participating employer who works 20 hours or more per week, and who is considered an employee for Social Security purposes. Partners and Proprietors are also considered to be eligible employees.

ELIGIBLE DEPENDENT

Eligible dependent is any of the following persons:

- Your spouse, and
- Your unmarried child, from birth to age 26.
- Each unmarried child at least 26 years of age who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation or physical handicap; who was incapacitated and insured under the Policy on his 26th birthday; and who continues to be incapacitated beyond his 26th birthday.

EMPLOYER RESTRICTIONS

This insurance plan is only available to employers that have been in business more than one year.

Most Firms will qualify for this plan; however, coverage is not available to:

- Groups funded by the government or any government agency
- Groups that are home based
- Groups that are seasonal in nature
- Groups with more than 90% family content
- Dental offices

This list of ineligible Firms is representative only and not all-inclusive.

GENERAL INFORMATION

PREMIUMS, RENEWABILITY

Applicable Dental Premium Rates are guaranteed for each Employer Group for 12 months from date of issue. Thereafter, rates are subject to change in accordance with the Master Policy. Coverage is renewable as long as eligibility criteria are satisfied and premiums are paid when due.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following dates: (a) the last day of the month in which You cease to be eligible for coverage; (b) the last day of the month in which Your Dependent is no longer a dependent as defined; (c) 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 (d) the date the Master Policy ends.

COORDINATION OF BENEFITS

This insurance plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits.

PARTICIPATION DISCOUNT

In the event the final dental employee participation reaches the greater of 3 employees or 50% of the eligible employees, your monthly premium rates charged may be reduced by 10%. Final approval of this discount is to be made by the Company. This discount does not apply to the Employer Paid rates.

EFFECTIVE DATE

When a firm joins the Trust, the insurance for its current employees will be effective on the date approved by the insurance company. Future new employees will become insured on the first of the month following the completion of the probationary period selected by the employer. A completed enrollment form must be received within 31 days of new employee eligibility. An employee who does not enroll when initially eligible is considered a "late entrant." A late entrant is eligible to enroll in the program as a "new employee" on the Plan's Anniversary Date or immediately if a qualifying event occurs.

REASONABLE AND CUSTOMARY

Reasonable and Customary means the usual, customary and regular charges for the area where such expenses are incurred.

NOT AVAILABLE IN: CT, NH, NY, SD, WA.

The insurance plan provides for an increase in coinsurance levels based upon each Benefit Year of coverage. Benefit Year begins with each insured's effective date and continues for 12 months. Each primary insured and/or dependent will have his own Benefit Year beginning with his specific effective date of coverage.

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This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Dental Policy Form GH-1112. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product is subject to individual state regulations. The policyholder may be a trustee group policyholder in some states.

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Rates effective July 1, 2014 - December 31, 2014

GemStar 1500 Dental Rates

Follow the steps below to find your **GemStar Dental** monthly policy rate:

1 Find your Area by locating the first 3 digits of your zip code

State	Zip	Area
Alabama	350-355, 359	3
	All Other	1
Alaska	995-996	8
	All Other	6
Arizona	856-857, 864	2
	All Other	1
Arkansas	All	1
California	956-958	3
	917-918, 943-948, 959	4
	906-914, 919-927, 930-934, 939, 949, 961	6
	900-905	7
	915-916	8
	All Other	5
Colorado	803, 808-810	4
	All Other	1
Delaware	All	2
D.C.	All	6
Georgia	300-303, 307, 311	2
	All Other	1
Hawaii	All	3
Idaho	All	1
Illinois	600-605	2
	606-608	3
	All Other	1
Iowa	All	1
Indiana	463-464	2
	473	3
	All Other	1
Kansas	660-662	2
	All Other	1
Kentucky	All	1
Louisiana	707-711	2
	712	3
	All Other	1
Maine	All	1
Maryland	206-207, 209-211	2
	217	3
	All Other	4
Massachusetts	All	5
Michigan	480-483, 490-491	2
	488-489	3
	All Other	1
Minnesota	553-558, 564, 566	2
	All Other	1
Mississippi	390-392	2
	All Other	1
Missouri	640-641, 644-649	2
	All Other	1
Montana	590-591	1
	599	2
	All Other	3
Nebraska	All	1
Nevada	890-891	2
	894-895, 898	6
	All Other	4
New Jersey	All	4
New Mexico	881	2
	882	5
	All Other	1
Ohio	All	1
Oklahoma	740-743	2
	All Other	1
Oregon	977	3
	978	1
	All Other	2
Pennsylvania	170-178, 182-187	2
	190-192	3
	All Other	1
Rhode Island	All	3
South Carolina	All	1
Tennessee	373-374	2
	All Other	1
Texas	756-757, 776-777	1
	751-753	3
	754	4
	All Other	2
Utah	All	1
Virginia	224-225, 230-232	1
	228-229, 240-244	2
	201, 220-221, 233-237	5
	222-223	6
	All Other	4
West Virginia	262-265	3
	255-257	4
	All Other	2
Wisconsin	All	1
Wyoming	All	1

MY AREA NUMBER

2 Find your dental rate by your Area and Contribution

Voluntary Area:	1	2	3	4	5	6	7	8	DENTAL RATE *per employee*
Employee Only	$23.80	$26.06	$28.71	$31.61	$34.76	$38.28	$41.81	$46.34	
Employee + Spouse	$48.35	$52.89	$58.18	$63.97	$70.39	$77.45	$85.00	$93.69	
Employee + Child(ren)	$56.92	$62.47	$68.50	$75.56	$83.11	$91.30	$100.11	$110.57	
Employee + Family	$86.39	$94.83	$104.02	$114.59	$126.06	$138.52	$152.12	$167.61	

Employer Paid* Area:	1	2	3	4	5	6	7	8	DENTAL RATE *per employee*
Employee Only	$21.63	$23.70	$26.10	$28.74	$31.60	$34.80	$38.01	$42.13	
Employee + Spouse	$43.96	$48.08	$52.89	$58.16	$63.99	$70.41	$77.27	$85.17	
Employee + Child(ren)	$51.74	$56.79	$62.27	$68.69	$75.56	$83.00	$91.01	$100.52	
Employee + Family	$78.54	$86.21	$94.56	$104.18	$114.60	$125.93	$138.29	$152.38	

**Requires 75% employer contribution for employee only, or 50% employer contribution for employee + dependent.*

3 Find the monthly dental premium for your group

	Base Rate	Discount: Package**	CPC Credit	Discount: 50% Participation***	Total Monthly Premium	# of Employees	Subtotal	Total Dental Premium for Group
Employee Only	$	x 0.95	x 1.14	x 0.90	= $	x =	$ =	
Employee + Spouse	$	x 0.95	x 1.14	x 0.90	= $	x =	$ =	
Employee + Child(ren)	$	x 0.95	x 1.14	x 0.90	= $	x =	$ =	
Employee + Family	$	x 0.95	x 1.14	x 0.90	= $	x =	$ =	

***A 5% discount is available for combined dental and vision packages. To receive the discount, at least two employees must sign up for dental coverage and at least two employees must sign up for vision coverage.*

****Available for Voluntary participation only, for groups with 3+ employees or 50% participation, whichever is greater*

Groups over 100 eligible employees must be submitted to the home office for review. A rate increase of 20% is required for schools and government bodies.

GEMSTAR℠ 1500

Vision Insurance for employer groups with 2+ lives

- No waiting periods
- Rate discount for combined dental and vision package
- Additional network discounts available

Vision Benefits – In Network

	9752007
EXAMINATION	
Frequency	Once every 12 months
Insureds Copay	$10
EYEGLASS LENSES	
Frequency	Once every 12 months
Insureds Copay	$10
FRAMES	
Frequency	Once every 12 months
Insureds Copay	$0
CONTACTS (in lieu of eyeglass lenses)	
Frequency	Same as eyeglass lenses
Insureds Copay	Same as eyeglass lenses

Vision Benefits – Out of Network

	The plan will pay:
Eye Examination	$25
Single Vision Lenses	$20
Bifocal Lenses	$40
Trifocal Lenses	$50
Frames	$40
Contacts (in lieu of eyeglass lenses)	$70

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WHAT THE BENEFITS INCLUDE

- **Eye Examination –** A routine, complete eye examination, refraction and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures which are the responsibility of the member.
- **Eyeglass Lenses –** Standard uncoated plastic lenses of any size or power.
- **Frames –** Any frame up to a regular retail value of $130. Frames above $130 retail are available at an additional charge.
- **Contact Lenses –** Any pair of contact lenses up to a regular retail price of $130 obtained from a network provider or the mail order program. Contact lenses above $130 are available at an additional charge.
- **LASIK –** Non-insured discount benefit. The EyeMed Access Network provides discounts to insureds interested in LASIK – a laser vision correction procedure. This non-insured benefit is offered at savings of 15% off the regular retail price or 5% off the promotional price when using the network.
- **2 year rate guarantee**
- **EyeMed Access Network –** EyeMed includes such familiar names as LensCrafters, Pearle Vision, Sears Optical and Target Optical along with thousands of independent optometrists, ophthalmologists and opticians. For more information or to find a participating doctor, call 866.723.0513 or visit **EnrollWithEyeMed.com/access**.
- **Additional Lens Option Benefits –** In network only, add to the lens price above and enjoy add-on benefits for a minimum copayment:

Add-Ons	Copayment
UV Coating	$15
Scratch Resistance	$15
Tint	$15
Polycarbonate	$40
Anti-Reflective	$45
Standard Progressive	$65
Other Add-Ons	20% Retail Discount

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BENEFIT PROVISIONS, LIMITATIONS AND EXCLUSIONS

VISION EXPENSES NOT COVERED

Limitations – In no event will payment exceed the lesser of:

- The actual cost of covered Services or Materials; or
- the limits of the Policy, shown on the coverage schedule.

Exclusions – We will not cover:

- Orthoptic or vision training and any associated supplemental testing;
- plano lenses;
- lens coatings;
- two pairs of glasses, in lieu of bifocals or trifocals;
- medical or surgical treatment of the eyes;
- any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- any injury or illness when covered under any Workers Compensation or similar law, or which is work-related;
- no-line bifocal or progressive lenses;
- photo-chromatic lenses;
- sub-normal vision aids or non-prescription lenses;
- services rendered or Materials purchased outside the U.S. or Canada, unless: a. the Insured resides in the U.S. or Canada; and b. the charges are incurred while on a business or pleasure trip.
- charges in excess of the Usual and Customary charge for the Service or Materials;
- charges incurred after; a. the Policy ends; or b. the Insured's coverage under the Policy ends, except as stated in the Policy;
- experimental or non-conventional treatment or device;
- spectacle lens treatments or "add-ons", except solid tints (#1 and #2), and oversize lenses;
- high index lenses of any material type;
- lost or broken Materials, except when replaced at normal intervals when Services are available.

UNDERWRITING GUIDELINES

ELIGIBILITY

Rates are guaranteed for a period of TWO YEARS from the effective date. Annual open enrollment.

ELIGIBLE EMPLOYEE

An individual employed by a participating employer who works 20 hours or more per week, and who is considered an employee for Social Security purposes. Partners and Proprietors are also considered to be eligible employees.

ELIGIBLE DEPENDENT

Eligible dependent is any of the following persons:

- Your spouse, and
- Your unmarried child, from birth to age 26.
- Each unmarried child at least 26 years of age who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation or physical handicap; who was incapacitated and insured under the Policy on his 26th birthday; and who continues to be incapacitated beyond his 26th birthday.

EMPLOYER RESTRICTIONS

This insurance plan is only available to employers that have been in business more than one year.

Most firms will qualify for this plan; however, coverage is not available to:

- Groups funded by the government or any government agency
- Groups that are home based
- Groups that are seasonal in nature
- Groups with more than 90% family content

This list of ineligible firms is representative only and not all-inclusive.

GENERAL INFORMATION

PREMIUMS, RENEWABILITY

Applicable Vision Premium Rates are guaranteed for each Employer Group for 24 months from date of issue. Thereafter, rates are subject to change in accordance with the Master Policy. Coverage is renewable as long as eligibility criteria are satisfied and premiums are paid when due.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following dates: (a) the last day of the month in which You cease to be eligible for coverage; (b) the last day of the month in which Your Dependent is no longer a dependent as defined; (c) 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 (d) the date the Master Policy ends.

COORDINATION OF BENEFITS

This insurance plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits.

EFFECTIVE DATE

The insurance for current employees will be effective on the date approved by the insurance company. Future new employees will become insured on the first of the month following the completion of the probationary period selected by the employer. A completed enrollment form must be received within 31 days of new employee eligibility. An employee who does not enroll when initially eligible is considered a "late entrant." A late entrant is eligible to enroll in the program as a "new employee" on the Plan's Anniversary Date or immediately if a qualifying event occurs.

NOT AVAILABLE IN: NH, NJ, NY, VT, WA.

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This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in Group Vision Policy GH-1157 for all states except IL, IA and MN; GH-1154 for IL, IA and MN. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product is subject to individual state regulations. The policyholder may be a trustee group policyholder in some states.

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SECURITYLIFE
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Rates effective October 1, 2013 - December 31, 2014

GemStar 1500 Vision Rates

Follow the steps below to find your **GemStar Vision** monthly policy rate:

1 Find your vision rate by contribution

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Voluntary	$8.25	$15.51	$13.42	$22.11

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Employer Paid*	$7.26	$13.42	$11.55	$19.03

*Requires 75% employer contribution for employee only, or 50% employer contribution for employee + dependent.

2 Find the monthly vision premium for your group

	Base Rate	Discount: Package**	Total Monthly Premium	# of Employees	Subtotal
Employee Only	$	x 0.95	= $	x =	$
Employee + Spouse	$	x 0.95	= $	x =	$
Employee + Child(ren)	$	x 0.95	= $	x =	$
Employee + Family	$	x 0.95	= $	x =	$
				Total Vision Premium for Group	$

***A 5% discount is available for combined dental and vision packages. To receive the discount, at least two employees must sign up for dental coverage and at least two employees must sign up for vision coverage.*

Vision unavailable for NH, NJ, NY, VT, WA.

GEMSTAR℠ 1500

Term Life/AD&D Insurance for employer groups with 2+ lives

Term Life/AD&D

$25,000

Benefits include:

- Guaranteed issue term life insurance, down to two lives
- Accidental Death & Dismemberment (AD&D) benefit package, including:
  - Seat belt/air bag benefit
  - Public transportation benefit
  - Education benefit
  - Repatriation benefit
  - Brain damage benefit
  - Coma benefit
  - Felonious assault benefit
- Accelerated death benefit
- Prompt claims processing–most paid within 7 business days
- 2 year rate guarantee
- Life and AD&D are sold as a package

Age Reduction

- Reduce to 50% of original amount at age 70

Participation Requirements

- Employer Paid
  75% participation or two non-related covered lives, whichever is greater
- Voluntary
  20% participation or five covered lives, whichever is greater

- Guaranteed issue down to 2 lives
- 2 year rate guarantee
- AD&D package included

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LIFE LIMITATIONS AND EXCLUSIONS

Life Insurance benefits will not be payable if death is caused by or results from suicide, whether sane or insane, within two years from the date coverage becomes effective.

AD&D LIMITATIONS AND EXCLUSIONS

A loss that is directly or indirectly a result of one or more of the following is not a Covered Loss even though it was caused by an accidental bodily injury:

- bodily or mental infirmity or disease of any kind, or an infection (unless due to an accidental cut or wound);
- medical or surgical treatment, except where it is both: (a) treatment of an injury that meets the tests of a Covered Loss; and (b) treatment performed within 90 days after the injury;
- your participation in a war or an act of war, declared or undeclared;
- your service in the armed forces of any country or international authority for a period longer than 15 days;
- your unlawful participation in a riot, rebellion, or insurrection;
- your attempting to commit, or committing, an assault or felony;
- an intentionally self-inflicted injury or illness while sane or insane;
- suicide or attempted suicide whether sane or insane;
- riding in or descending from any kind of aircraft: as a passenger on an aircraft operated by or for the armed forces; or as a pilot or crew member. (A crew member is anyone who has duties at any time on the flight, involving either the flight or the aircraft); or as a participant in aviation training (student or instructor); or as a participant in a sporting event or hobby;
- your intoxication, as defined under the laws of the jurisdiction in which your Covered Loss occurred, except in the case of a narcotic that was administered or consumed on the advice of a physician; or the voluntary taking of any kind of gas, except during the course of employment; the voluntary taking of any poison except in the case of accidental food poisoning; or participating in any hazardous activity such as: Scuba Diving, Bungee Jumping, Skydiving, Hang Gliding, Ballooning, Drag Racing, Competitive Racing, Aerial Hunting, Aerial Skiing, and Parachuting; or work or service in a country that is included or has been included in the past six months on the International Travel Warning list that is issued by the U.S. Department of State (www.travel.state.gov).

UNDERWRITING GUIDELINES

MINIMUM GROUP SIZE

Plan offered to groups with 2 or more non related full time employees; or 5 or more full time employees for voluntary groups.

EMPLOYEE ELIGIBILITY

Full time employees working 20 or more hours per week are eligible. Voluntary group employees must enroll within 31 days of becoming eligible or be subject to providing evidence of insurability, (product does not include annual open enrollment).

GROUP ELIGIBILITY

The plan is available to employers that have been in business more than one year. Coverage is not available to:

- Groups funded by the government or any government agency.
- Groups that are home based or seasonal in nature.
- Groups with more than 90% family content, for groups with 2-9 lives.
- Groups with an eligible employee age 70+ (applied only to groups with 2-9 eligible lives).
- Groups with the following SIC Codes: 721, 811 to 1499, 2411 to 2431, 2892, 3292, 3482 to 3492, 4011 to 4173, 4215, 4311 to 4581, 5921, 7363, 7382, 7521, 7996, 7999, 8611 to 8699, 8811 to 9111, 9211 to 9999.

This list of ineligible Firms is representative only and not all-inclusive.

MINIMUM PARTICIPATION REQUIREMENTS

100% of employees must participate if employer pays the full cost of the coverage. At least 75% of employees must participate if employees contribute toward the cost with a minimum of 2 covered lives.

MINIMUM PARTICIPATION REQUIREMENTS – VOLUNTARY GROUPS

At least 20% of employees (or 5 employees, whichever is greater) must participate. This requirement must be maintained at renewal.

PLAN REDUCTION

Plan will reduce to 50% of original amount upon employee's attainment of age 70.

NOT AVAILABLE IN: CO, CT, FL, MA, NH, NY, RI, TX, VT, WA

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This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in Group Life Policy GP2010MP (and any state specifics). Premium rates may change upon renewal. This policy is renewable at the option of the Company.

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SECURITYLIFE
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Rates effective January 1 through December 31, 2014

GemStar 1500 Life Rates

Follow the steps below to find your **GemStar Life/AD&D** monthly premium:

1 Find employees' monthly premium by locating their age and gender under the applicable contribution level for the group.

Employer Paid Monthly Premium		
Age	**Male**	**Female**
Under 30	$3.50	$2.25
30-39	$3.75	$2.50
40-49	$8.00	$4.25
50-59	$20.75	$9.50
60-69	$38.50	$17.50
70+*	$92.63	$69.50

Voluntary Monthly Premium	
Age	**Premium**
Under 30	$3.00
30-39	$3.25
40-49	$5.50
50-59	$14.75
60-69	$34.00
70+**	$74.75

**Employer Paid groups with less than 10 employees are ineligible if they have any employee age 70+.*

***Voluntary coverage is not available for groups with less than 5 covered employees. Employees age 70+ are not eligible for coverage if the employer group has 5-9 eligible employees.*

The Life/AD&D Benefit is $25,000 for under age 70 and $12,500 for age 70+.

2 Use the following chart to determine each employee's monthly premium.

Employee Name	Male / Female	Age	Monthly Premium
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$

If you require more room, please use a separate sheet to calculate.

Total Life/AD&D Premium for Group $

Life/AD&D unavailable for CO, CT, FL, MA, NH, NY, RI, TX, VT, WA.

Security Life Insurance Company of America
10901 Red Circle Drive
Minnetonka, Minnesota 55343
800.233.0307

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

GemStar 1500 Employer Group Insurance Application

Employer Name	Contact	
Address		Nature of Business
City	State	Zip	☐ Corporation ☐ Partnership ☐ Sole-Proprietor ☐ Other
Telephone Number	Fax Number	Email Address

Number of years Employer in business _____

Subsidiaries and affiliates included? ☐ Yes ☐ No
If yes, please provide the name and address of the subsidiaries and affiliates whose employees are to be covered:
_____

Effective Date Requested

_____, ☐ 1st or the ☐ 15th, _____
Month *Day* *Year*

Initial Probationary Period
- NONE for current employees
- _____ days/months for future employees

New hires effective the first of the month following probationary period.

DENTAL *(not available in CT, NH, NY, WA)*

☐ Voluntary ☐ Employer Funded

Employer agrees to contribute:
- Employee $_____ or _____ %
- Employee + One $_____ or _____ %
- Employee + Child(ren) $_____ or _____ %
- Employee + Family $_____ or _____ %

There are initially _____ full-time employees of which _____ will be enrolled in this plan.

Current Dental Plan:
- Is this group currently enrolled under another group dental program? ☐ Yes ☐ No
- Are CPC benefits requested? ☐ Yes ☐ No
- Include a copy of the current plan and last billing.

VISION *(not available in NH, NJ, NY, VT, WA)*

☐ Voluntary ☐ Employer Funded

Employer agrees to contribute:
- Employee $_____ or _____ %
- Employee + One $_____ or _____ %
- Employee + Child(ren) $_____ or _____ %
- Employee + Family $_____ or _____ %

There are initially _____ full-time employees of which _____ will be enrolled in this plan.

GHA-1154 / GH-1157 / GH1157(KY) / GHA-1157(LA) / GH-1157(MD)

LIFE *(not available in CO, CT, FL, MA, NH, NY, RI, TX, VT, WA)*

☐ Voluntary ☐ Employer Funded	Employer agrees to contribute $_____ or _____ % for the employee.	There are initially _____ full-time employees of which _____ will be enrolled in this plan.

The undersigned Employer hereby requests to insure eligible persons under Group Dental Policy GH-1112 (and any state specifics) and Group Vision Policy GH-1154 or GH-1157 (and any state specifics) (policyholder may be a trustee group policyholder in some states) and Group Life Policy GP2010MP (and any state specifics) insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

It is agreed that the policy will become effective at rates to be determined by us, provided the application is accepted by us. The applicant declares that to the best of its knowledge and belief that statements and answers are complete and true.
Be sure to include Employee Applications when you submit this Employer Application.

_____ _____
Authorized Signature *Date*

Submit Application *(must submit with Payment Authorization Form and Employee Applications)*

MAIL	**FAX**
Security Life Insurance Company of America P.O. Box 10095 | Lancaster, PA 17605	717.481.7175

If accepted, the 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 all employees. The 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 two (2) non-related employees of the employer's eligible employees must be enrolled in the Dental and/or Vision Plan to prevent cancellation of coverage. This plan does not require any contribution from the employer. To be eligible for the Employer paid premium rates illustrated, the employer agrees to contribute no less than 75% of the employee only premium or 50% of the combined employee/dependent premiums. The Employer requests that benefits be made available to all employees subject to the following condition: no coverage for any employees shall take effect until this Application and the employee's individual enrollment forms are accepted by the Company and the initial premium is paid.

Important Fraud Notices

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.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

CA: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: 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.

DC: 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.

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

ID and KS: 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.

KY: 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.

LA and RI: 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.

ME: 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 benefit.

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MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

NM: 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.

NC: 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 may subject such person to criminal and civil penalties.

OH and VA: 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: in OH, guilty of insurance fraud; in VA, may have violated state law.

OK: 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.

OR: 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.

PA: 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 to and civil penalties.

TN: 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.

For Agent use only

Agent Statement: I hereby certify that all the information contained in this Group Insurance Application 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 coverage to the entity.

Agent Name		Phone #	
Street Address	City	State	Zip
Email	SS#/TIN#		
Security Life Agent Authorization #	Signature		

P.O. Box 10095 | Lancaster, PA 17605
800.300.9566 | SecurityLife.com

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

GemStar 1500 Payment Authorization Form

Applicant's Full Name:

Monthly Premium (from Rate Sheet):

Method of Payment (select one)

CHECKING ACCOUNT (ACH)

☐ **Monthly Bank Account Debit**
Submit 1 months premium and a voided check

☐ **Quarterly Bank Account Debit**
Submit 3 months of premium and a voided check

CREDIT CARD

☐ **Monthly Credit / Debit Card**

Please select your card type below and provide your credit card account information:

☐ Visa ☐ MasterCard ☐ Discover

_____
Credit Card Number

_____
Expiration Date

PAPER BILL

☐ **Monthly Paper Bill**
** *Initial invoice will be for two months premium and then monthly after that.*

☐ **Quarterly (3 months) Paper Bill**
** *All invoices will be for 3 months and sent quarterly.*

Paper billing begins on your policy effective date and we will provide you with an invoice of charges due for the insurance policy.

***Claims will not be processed until the initial payment is received.*

Authorization Agreement

I authorize Security Life Insurance Company of America to initiate electronic debit entries to my account chosen above for payment of my insurance premium. My account will be debited by the third business day of the month in which premium is due. I understand I will receive a notice if the amount changes. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of the US law. (Applies only to ACH and Credit Card options.)

I understand that in order to make changes to this authorization (such as a change in bank account, method of payment, or termination of payment) I need to give Security Life written notification at least 10 days prior to the next scheduled payment. I understand that the insurance plan may be cancelled by Security Life if any payment is dishonored by my bank for any reason. In the case of an NSF, I am liable for any fees my bank may charge me and may also be responsible for an NSF fee of up to $25 which may be automatically debited for each NSF.

Your Signature _____ **Date** _____

Submit Payment Form (must submit with Employer and Employee Applications)

MAIL	**FAX**
Security Life Insurance Company of America P.O. Box 10095 | Lancaster, PA 17605	717.481.7175

Security Life Insurance Company of America
10901 Red Circle Drive
Minnetonka, Minnesota 55343
800.233.0307

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

GemStar 1500 Group Insurance Employee Enrollment Form

EMPLOYER SECTION *(to be filled out by employer)*

Employer Name	Full-Time Hire Date
Address	Phone Number

EMPLOYEE SECTION

Last Name	First Name		Middle Initial
Address			Date of Birth (MM/DD/YYYY)
City	State	Zip	Marital Status ☐ Married ☐ Single
Telephone Number	Regular Number of Hours Worked per Week?		Gender ☐ Male ☐ Female

COVERAGE ELECTION: ☐ Dental ☐ Vision ☐ Life *(select all that apply)*

DEPENDENTS (list all your eligible dependents below)

LAST NAME	FIRST NAME	INITIAL	GENDER	AGE	BIRTH DATE
			☐ M ☐ F		____/____/____
			☐ M ☐ F		____/____/____
			☐ M ☐ F		____/____/____
			☐ M ☐ F		____/____/____

If additional dependent information is needed, please include on a separate sheet of paper.

BENEFICIARY

NAME	RELATIONSHIP	PRIMARY/CONTINGENT

Does your spouse have a dental/vision plan? ☐ Yes ☐ No	If yes, with whom?	If yes, are dependents enrolled under your spouse's plan? ☐ Yes ☐ No

Group Dental Coverage is provided under the Group Dental Insurance Policy GH-1112 (and any state specifics) issued to the Group Policyholder (policyholder may be a trustee group policyholder), and Group Vision Coverage under the Group Vision Policy GH-1154 or Policy GH-1157 (and any state specifics) issued to the Group Policyholder (policyholder may be a trustee group policyholder in some states), and Group Life Policy GP2010MP (and any state specifics), all insured by Security Life Insurance Company of America, Minnetonka, Minnesota.

By my signature below, I hereby apply for the coverage or coverage's selected above. I represent/certify that I have read the applicable Fraud Notice provided. 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.

Applicant Signature _____ **Date** _____

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