

**Union Security DentalCare
of Georgia, Inc. Application Form**

**Select Individual
Prepaid Dental Plan**

REP NUMBER

4d00526

| | | | | | | |
|-----------------------------|-----------|------------|------------|--------------------------------|--|--|
| Your Social Security Number | Last Name | First Name | Middle I. | Sex M <input type="checkbox"/> | IMPORTANT Write the Dental Facility ID Number of the dentist(s) you choose from the directory in the space(s) below. | |
| | | | | F <input type="checkbox"/> | | |
| Your Date of Birth / / | Address | | | | | |
| Home Phone () | City | State | Zip Code+4 | | | |

| List Dependents to be Enrolled | | | | | Dental Facility Number | |
|--------------------------------|-----------|--------------------------|--------------|---------------|---|--|
| First Name | Middle I. | Last Name (if different) | Relationship | Date of Birth | Sex | |
| Spouse | | | | / / | M <input type="checkbox"/> F <input type="checkbox"/> | |
| Child | | | | / / | M <input type="checkbox"/> F <input type="checkbox"/> | |
| Child | | | | / / | M <input type="checkbox"/> F <input type="checkbox"/> | |

Attach a separate sheet of paper for additional children.

| | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Prepayment Fee Amount \$ _____ +Enrollment Fee \$ 35.00 Total Enclosed \$ _____ | <input type="checkbox"/> Annual Payment - make the check payable to Union Security Insurance Company. | <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover | | | | | | | | | | | | | | | | | | | | |
| | Select Payment Choice <input type="checkbox"/> Charge my annual prepayment fees | Mo. _____ Yr. _____ <table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table> | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Automatic Monthly Bank Draft - complete the Authorization Agreement | | | | | | | | | | | | | | | | | | | | | | |

By my signature below, I understand that this Individual Prepaid Dental Plan is a non-refundable one (1) year program. I also understand that a full description of plans will be provided in the Individual Prepaid Dental Plan Agreement and that the dentist I select may or may not perform all of the procedures listed on the Copayment Schedule. I authorize the dentist who has rendered procedures to me or members of my family to make available to Union Security Insurance Company my dental records, photocopies or information regarding such procedures to the extent permitted by law.

Agent's Signature *Thomas J. Carter* Date _____ Subscriber's Signature _____ Date _____

11.60 18.63 28.37
127.20 211.56 328.44
KC4173AGA-E

Please retain a copy of this application for your records. This is an important document that will become part of your contract.

Mail To: Dental Agents
3752 Tulip Tree Rd.
Marietta, GA 30066-2928
Or Fax To: 678-623-3913

Authorization Agreement For Automatic Monthly Bank Draft

| | | | | | | | | | | | | | | | | |
|---------|------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------------|----------------------------------|
| Name(s) | Social Security Number | | | | | | | | | | | | | | Checking <input type="checkbox"/> | Savings <input type="checkbox"/> |
|---------|------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------------|----------------------------------|

IMPORTANT

If you selected the Monthly Bank Draft Payment method, enclose a voided check, your first month's prepayment fee and \$35 enrollment fee with this form and send them to us.

I (we) hereby authorize Union Security Insurance Company to initiate debit entries, and to initiate if necessary, credit entries and adjustments for any debit entry corrections to my (our) account indicated below and the Financial Institution named below to debit and/or credit same to such account.

| | | |
|-----------|------|-------|
| Bank Name | City | State |
|-----------|------|-------|

Include your Checking or Savings Account Number in the boxes below:

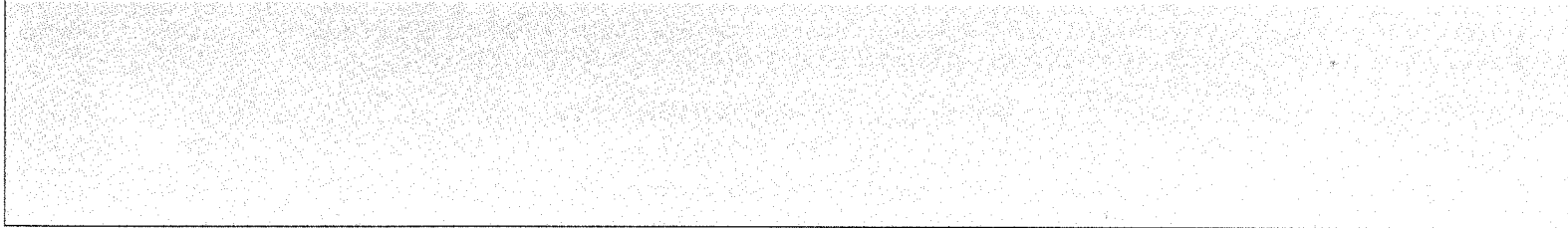
| | | | | | | | | | | | | | | | | | | | |
|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Account Number | | | | | | | | | | | | | | | | | | | |
|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

Prepayment fees are deducted from your authorized account on the 15th of the month prior to the month of benefits. The Authorization Agreement automatically renews if the Individual Dental Service Agreement renews.

| | | | |
|---|----------------|-------------|---------|
| John M. Doe Mary J. Doe 210 East Anystreet Youngstown NJ 07095 | _____ 20 _____ | 3780 | 3-6-340 |
| Pay to the ORDER OF _____ | VOID | _____ | DOLLARS |
| CP CENTRAL NATIONAL BANK Youngstown, NJ | | | |
| Memo _____ | | | |
| AC31000095 285 414 3A 3780 | | | |

This authorization is to remain in full force and effective until Union Security Insurance Company has received WRITTEN notification from me (or either of us) of its termination by the 10th of the month prior to the month when the enrollment is to be terminated.

Signature _____ Date _____



Sample Copayments for the Select Prepaid Individual Dental Plan

The following is a sample of some of the most frequently used dental procedures. When you enroll for the DentiCare plan, you will pay discounted fees called copayments. These discounts are only available from providers who participate in our network. After you enroll, a

| DENTAL TREATMENT | YOUR COST | |
|--|----------------------|------------------|
| | With the Select Plan | Without the Plan |
| APPOINTMENTS | | |
| Periodic Oral Evaluation | \$5.00 | \$27.00 |
| Limited Oral Exam | \$25.00 | \$45.00 |
| Comprehensive Oral Evaluation | 5.00 | \$47.00 |
| DIAGNOSTIC DENTISTRY | | |
| Complete X-Ray Series, Including Bitewings | No Charge | \$84.00 |
| PREVENTIVE DENTISTRY | | |
| Routine Cleaning - Adult (once every 6 mos.) | \$5.00 | \$54.00 |
| Routine Cleaning - Child (once every 6 mos.) | \$5.00 | \$41.00 |
| Application of Fluoride (up to 15 years of age) | No Charge | \$21.00 |
| Oral Hygiene Instruction | No Charge | \$27.00 |
| Application of Sealant, Per Tooth | \$15.00 | \$33.00 |
| Fixed Space Maintainer | \$70.00* | \$203.00 |
| FILLINGS/CROWNS | | |
| Silver Fillings | | |
| One Surface | \$25.00 | \$71.00 |
| Two Surfaces | \$30.00 | \$87.00 |
| Three Surfaces | \$40.00 | \$99.00 |
| White Fillings | | |
| One Surface, Anterior | \$40.00 | \$94.00 |
| Two Surfaces, Anterior | \$50.00 | \$114.00 |
| Three Surfaces, Anterior | \$60.00 | \$141.00 |
| One Surface, Posterior | \$40.00 | \$91.00 |
| Two Surfaces, Posterior | \$50.00 | \$113.00 |
| Three Surfaces, Posterior | \$60.00 | \$135.00 |
| Crowns - Porcelain to High Noble Metal (cost of porcelain & semi-precious metal is additional) | \$320.00* | \$730.00 |
| Labial Veneer - Chainside | \$225.00* | \$347.00 |
| ROOT CANALS | | |
| Anterior | \$225.00 | \$501.00 |
| Bicuspid | \$345.00 | \$594.00 |
| Molar | \$545.00 | \$751.00 |
| PERIODONTICS | | |
| Periodontal Sealing and Root Planning Per Quadrant | \$75.00 | \$169.00 |
| Full Mouth Debridement (compleat coverage) | \$95.00 | \$101.00 |

complete list of copayments will be mailed to your home along with your Individual Prepaid Dental Plan Agreement. The sample below demonstrates potential savings with the DentiCare plan and may not reflect your actual results.

| DENTAL TREATMENT | YOUR COST | |
|---|----------------------|------------------|
| | With the Select Plan | Without the Plan |
| DENTURES | | |
| Complete Denture - Upper | \$350.00* | \$923.00 |
| Complete Denture - Lower | \$350.00* | \$984.00 |
| Partial Denture - Upper | \$395.00* | \$616.00 |
| Partial Denture - Lower | \$395.00* | \$620.00 |
| ORAL SURGERY | | |
| Single Tooth Extraction | \$30.00 | \$85.00 |
| Removal of Impacted Tooth | \$80.00 | \$207.00 |
| Soft Tissue | \$90.00 | \$276.00 |
| Partial Bony | \$115.00 | \$320.00 |
| Complete Bony, with Complications | \$165.00 | \$370.00 |
| ORTHODONTICS | | |
| Orthodontic treatment for children and adults is provided at 25% reduction from the Plan Specialist or Plan Dentist's list charges. | | |

The Plan Dentist you select may not perform all procedures listed. The copayments shown apply to those Plan Dentists who perform those services. Therefore, you are encouraged to discuss availability of the scheduled services with your Plan Dentist. Charges for procedures not listed on the Copayment Schedule that are performed by your Plan Dentist are not covered under your Plan with DentiCare.

Should you require dental services that your Plan Dentist is unable to provide, you may obtain those services from a Plan Specialist at a discounted rate. No referral is needed from your Plan Dentist in order for you to obtain services from Plan Specialist. There is no applicable copayment schedule for Plan Specialist services. Instead, the following discounts will apply. For treatment provided by an Endodontist you will receive 15% off his/her list charges. For treatment provided by an Oral Surgeon, Orthodontist, Periodontist or Pedodontist you will receive 25% off his/her list charges. You will be responsible for paying the entire discounted charge at the time the service is received, or in accordance with the Plan Specialist's billing procedures.

For a complete list of copayments contact:

888-882-8233

*Members are responsible for additional lab fees for these services.

The charges listed in this column were developed from charges dentists in Georgia submitted to Fortis Benefits Insurance Company in 2002.

DentiCare's Select Individual Prepaid Dental Plan

DentiCare provides you an individual dental plan with quality benefits and attractive prepayment fees. To receive the benefits of the DentiCare SelectSM Plan you will need to select a Plan Dentist for you and your family members from the list of Plan Dentists. Please note that you may choose a different Plan Dentist for each family member.

Features of the DentiCare SelectSM Plan:

- ┆ No deductibles
- ┆ No claim forms
- ┆ No annual dollar maximum for plan dentists and specialists
- ┆ Fixed Copayment Schedule
- ┆ Discounts on Orthodontic procedures for children and adults
- ┆ No referral required for Specialist benefits
- ┆ Benefits for pre-existing dental conditions
- ┆ Enroll by phone for the annual prepayment fee method

Prepayment Fee Options

Economical Annual Prepayment Fee

| | |
|----------------------------|----------|
| Individual | \$127.20 |
| Individual & One Dependent | \$211.56 |
| Family | \$328.44 |

or

Automatic Monthly Bank Draft

Accounts are drafted on the 15th of each month prior to the month of benefits.

| | |
|----------------------------|---------|
| Individual | \$11.60 |
| Individual & One Dependent | \$18.63 |
| Family | \$28.37 |

\$35.00 Enrollment Fee

How does the plan work?

Dentists who participate in this prepaid dental plan have agreed to offer services to plan members at a discount. Members pay the Plan Dentist his or her discounted fee directly. These discounted fees are called copayments. Not all services are subject to discounts. A sample of the copayments for this plan is included in this brochure.

Cosmetic dentistry

We know how important a great smile is to you, as well as the benefits of having the smile that you want and deserve. That's why we have included some cosmetic procedures, such as bleaching and bonding, in the list of copayments.

Vision discount plan

A vision discount plan is included with your dental plan. The vision plan includes discounts on eye exams, eyeglasses, contact lenses and other prescription eyewear when provided by participating providers. Upon your enrollment, information regarding the vision plan will be mailed to you. For more information on the vision discount plan, call 800-877-7195.

Orthodontic benefits

The Select Plan includes discounts on Orthodontic procedures for children and adults. Plan Orthodontists provide discounts of 25% off his or her list charge. Orthodontic services are available only in areas where DentiCare has Plan Orthodontist(s) or Plan Dentist(s) who provides those services. Orthodontic treatment begun prior to your plan effective date is not eligible for this discount.

Specialist benefits

Should the service of a specialist (Oral Surgeon, Endodontist, Orthodontist, Periodontist, or Pedodontist) be necessary you may seek treatment from any Plan Specialist listed in our printed or online directory. If an Oral Surgeon, Orthodontist, Periodontist or Pedodontist provides treatment you will receive 25% off list charges. For treatment by an Endodontist you will receive 15% off list charges. Specialist services are available only in areas where DentiCare has Plan Specialist(s).

Please note that payment for a service performed by a Non-Plan Specialist is your responsibility.

How do I join?

Three easy steps to enrolling in the Select Plan:

- 1 Select** a general dentist from the Plan Dentist Directory. Each family member may choose a different Plan Dentist.
- 2 Complete** the attached application form. Be sure to include the Dental Facility Number of each dentist you have selected in the space provided and detach the application form from the brochure.
- 3 Choose** your payment option.

If you choose the **annual prepayment fee method** include the appropriate prepayment fee, the \$35 enrollment fee, the completed application form and mail to Fortis Benefits. The annual prepayment fee may be paid by credit card for your convenience. You may enroll over the phone if you are choosing the annual prepayment fee method.

If you choose the **automated monthly bank draft method** complete the Authorization Agreement on the reverse side of the application form, include a voided check, the first month's prepayment fee, the \$35 enrollment fee and mail to Fortis Benefits. Monthly prepayment fees will thereafter be drawn automatically from your bank account. While we accept automatic bank drafts from checking or savings accounts, we cannot accept personal checks on a monthly basis.

When will I receive a membership card?

Once your application has been processed, you will receive a membership card, the Individual Dental Prepaid Plan Agreement, and a complete list of copayments.

What if I need to change my dentist?

You may make a request to change dentists at anytime by simply calling Customer Service at 800-443-2995 to select another participating provider.

Who is eligible?

You, your spouse or domestic partner and legal dependents under the age of 28 are eligible for dental benefits.

Mail To:

Georgia Dental Agents

Attn: Jerry W. Crater

3752 Tulip Tree Road

Marietta, GA 30066-2928

Or Fax To (Credit Card Only):

678-623-3913

Limitations and Exclusions

1. Medical costs associated with dental procedures.
2. Dental services or procedures which are not listed on the Benefits and Copayment Schedule.
3. Emergency Services received from a dentist who is not Member's selected Plan Dentist.
4. Certain services may only be obtained once in any six calendar months, with a maximum of twice in the same calendar year. Those services are listed on the Benefits and Copayment Schedule as ADA Codes 0120, 0150, 0272 and 0274.
5. Certain services may only be obtained once in any 3 calendar years. Those services are listed on the Benefits and Copayment Schedule as ADA Codes 0210 and 0330.
6. Services rendered by a Plan Provider because of behavior adjustment. Such services include, but are not limited to, physical restraint or sedation.
7. Replacement of dentures or appliances received during enrollment in Plan, if Member has had dentures or appliance less than five years. (Note: If dentures or appliance becomes unserviceable due to illness or causes not controlled by ordinary means, the following will apply. Replacement will be made only if existing denture or appliance cannot be made serviceable.)
8. Replacement of dentures, appliances or bridgework due to loss of teeth.
9. Dental treatment provided or started prior to Member's eligibility to receive benefits.
10. Dental treatment started after Member's termination.
11. Dental treatment caused by failure to follow prescribed treatment.
12. Ongoing orthodontic treatment past eighteen (18) consecutive months.
13. Orthodontic treatment involving therapy for myofunctional problems, T.M.J. dysfunctions, micrognathia, macrognathia, cleft palate or hormonal imbalances causing growth and developmental abnormalities.
14. Orthodontic cases involving orthognathic surgery.
15. Treatment for malignancies, neoplasms or cysts (including biopsies).
16. Lab fees associated with services listed on the Benefits and Copayments Schedule.
17. Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure loss by attrition.
18. Fixed prosthetic restoration of six (6) or more existing teeth, when performed as a single procedure or as part of a complete oral rehabilitation or reconstruction.
19. Complete oral rehabilitation or reconstruction involving replacement of six (6) or more missing teeth using fixed prosthetic restorations and/or appliances.
20. Dental treatment if Member's general health or physical limitations prevent Plan Provider from rendering appropriate dental treatment.
21. Costs associated with prescriptions or over the counter medications.
22. Implants, surgery for the insertion of implants, all related implant appliances and restorations, whether removable or fixed.
23. Surgical removal of implants, or any surgery required to adjust, replace, or treat any problem related to an existing implant, or implant appliance.