

**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 \_\_\_\_\_ Allied Brokerage Services \_\_\_\_\_ # \_\_\_\_\_ 040000000

**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	<b>North Carolina**</b>	0.91
<b>Connecticut</b>	<b>1.19</b>	275-277	1.00
<b>068-069</b>	<b>1.28</b>	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 Calculation Chart (CT)  
Underwritten by Standard Security Life Insurance Company of New York

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 monthly administration fee. + \$ 5.00
- Subtotal** \$ \_\_\_\_\_
- Multiply by number of months [\_\_\_\_(months) x \$\_\_\_\_\_(subtotal) =] + \$ \_\_\_\_\_
  - Add the **ONE-TIME** enrollment fee + \$ 20.00
- Total Due** \$

**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