

**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**

Please refer to the fraud warning statement for your state as indicated below.  
 Residents of Florida: 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 in the third degree.

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 \_\_\_\_\_

Florida License Agent ID # \_\_\_\_\_

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
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
<b>Florida</b>	<b>1.00</b>	430-432, 434-436	0.91
<b>330, 332-334, 340</b>	<b>1.09</b>	439-445, 450-452	0.91
<b>331</b>	<b>1.19</b>	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 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**