



**SelectDent
Employer Adoption Agreement
San Francisco Trial Lawyers Association**

Select Your Dental Plan(s)		
Group Plans: <input type="checkbox"/> Silver <input type="checkbox"/> Gold <input type="checkbox"/> Platinum	Voluntary Plans: <input type="checkbox"/> Deluxe <input type="checkbox"/> Deluxe Plus	Effective Date (limited to 1 st or 15 th)

Employer Information				
1	Full Legal Business Name	Tax ID Number		
2	Billing Address: Street	City	State	Zip
3	Mailing Address if different from above	City	State	Zip
4	Administrative Contact Person	Phone #	Fax #	Email

Affiliates / Subsidiaries whose employees are to be covered						
5	Company Name	Address	City	State	Zip	Separate Invoice to this address? <input type="checkbox"/> Yes <input type="checkbox"/> No
6	Administrative Contact Person	Phone #	Fax #	Email		

Misc.			
Probationary period for new hires: (new hires will be effective on the 1 st of the month following completion of employer's probationary period.) <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> other _____			
8	_____ Initial here to select the Out of Network UCR Option for Group Plans only. If selected, Non-Participating Providers are paid at the 80th percentile UCR.		
9	Total Employees:	# Eligible Employees:	# Employees Enrolling: _____ Employer Contribution _____ %

Employer's Signature	
<p>The undersigned employer hereby requests to participate in the Employers' Voluntary Benefit Insurance Trust issued under policy series GH-1112-34740 (Dental) and if elected in the Group Vision Coverage provided under the Group Vision Policy GH-1157 issued to the Group Policyholder insured by Security Life Insurance Company of America, Minnetonka, Minnesota. The employer hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified. If accepted, to the undersigned 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 the employees. The undersigned 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.</p> <p>Effective Date: The effective date of a participating employer unit shall be limited to the first or the fifteenth of the month. Employer units requesting a fifteenth of the month effective date need to submit 1½ months premium as billing date is always the first of the month. Eligibility Date: Eligibility for present Employees will be the initial Effective Date, while new hires will be eligible on the first of the month following one month of continuous employment unless other provisions have been agreed upon between the Administrator and the Participating Employer Unit. Premiums: Applicable Premium Rates are guaranteed for twelve (12) months from Employer's Initial Effective Date. Thereafter, premium rates are subject to change in accordance with the Master Policy. The undersigned Employer request the benefits be made available to all employees subject to the following conditions: (a) no coverage for any employees shall take effect until this agreement and the employee's individual enrollment cards are accepted by the Plan Coordinator in the initial premium paid; and (b) Employer agrees to remit regularly, in advance, the required premium payments to the Administrator and acknowledges and agrees that this plan is established under and is subject to the provisions of the Employer Retirement Income Security Act (ERISA), as amended. The undersigned Employer is the Plan Administrator as defined in ERISA, as amended. Termination Policy: A thirty (30) Day written notice is required for cancellation. Fraud Notice: Any person who knowingly presents a false or fraudulent claim for payment of 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.</p>	
X	

Authorized Signature	Name and Title (please print)	Date
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Producer's Statement			
Producing Agent Name	Agency Name Myers-Stevens-Mello	Phone Number 650.871.2570	Fax Number 650.871.2581
Street Address 1111 Bayhill Drive, Suite 275		Dept of Insurance License Number 0F04106	Producer's Tax ID 20-3212048
City San Bruno	State CA	Zip 94066	General Agency Name Word & Brown
Commissions Payable to: Agency		GA Representative	GA Tax ID # (for reporting commissions) 95-3161239
			GA Underwriter

Producer's Signature		
X		
Producer's Signature	Print Name	Date
I hereby certify that all the information contained in this Adoption and Participation Agreement 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's to the entity.		

Return this form, employee enrollment forms, any necessary supporting documentation and a check for the first month's premium payable to **Security Insurance**:

Myers-Stevens-Mello & Co., Inc.
1111 Bayhill Dr., #275 *San Bruno*CA*94066

Form S10975/ 12/07

PARTICIPATION AND UNDERWRITING GUIDELINES

Participating Employers

Employer Firms with at least 3 employees and that meet the underwriting guidelines of Security Life Insurance Company of America (the Company), qualify to apply for coverage. The Company has the right to decline the application of any firm.

Employee Eligibility

Unless specifically excluded by the employer, any employee of a participating employer actively working full-time (30 hours or more per week) will become eligible for insurance under this policy. The employee effective date will commence on the first billing date following the probationary period after the date of full-time employment, or the date the application form was completed provided premium has been paid on behalf of the employee by the employer.

Dependent Eligibility

Eligible employee may enroll eligible dependents on the date the employee becomes eligible for insurance under the policy, or on the first date he/she acquires a new dependent. A dependent is, (1) a spouse who is not legally separated from the employee; (2) unmarried child(ren): natural child(ren), legally adopted child(ren), child(ren) placed for adoption, stepchild(ren), foster child(ren) and legally appointed minor wards who rely on the employee for at least half of their support and maintenance and who are less than 19 years of age, or unmarried children under the age of 23 attending an accredited university of college on a full time basis.

Effective Dates

1st or 15th of the month. Note: Initial Effective dates of the 15th of the month will renew on the first of the month following 11 ½ months on the plan.

Participation Requirements

Three active employees with:

Group: 75% of eligible employees enrolling

Voluntary: 1 employee enrolling

LIMITATIONS & EXCLUSIONS

The Policy under which your certificate will be issued covers services and procedures as described in the Coverage Schedule. Your coverage under the policy does not cover any miscellaneous separate expense not considered a covered service or procedure.

WE WILL NOT PAY:

1. for overdentures and associated procedures.
2. for charges in excess of those considered reasonable and customary.
3. for cosmetic procedures.
4. for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
5. for implants, unless included in the coverage schedule; and for:
 - a. replacement of lost or stolen appliances;
 - b. replacement of retainers;
 - c. athletic mouthguards;
 - d. precision or semi-precision attachments; or
 - e. denture duplication.
6. for oral hygiene instructions; and for:
 - a. plaque control;
 - b. completion of a claim form;
 - c. acid etch;
 - d. broken appointments;
 - e. prescription or take-home fluoride; or
 - f. diagnostic photographs.
7. 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.
8. for procedures that are begun, but not completed.
9. for services and treatment provided without charge or for which there would be no charge in the absence of insurance.

Contribution Requirements

Group: Employer must contribute 50% of the Silver Plan employee only premium.

Voluntary: No employer contribution required.

Rate Guarantee

Rates are guaranteed for the first 12 months following the Employer's original effective date with the plan.

New Enrollees

Eligibility for coverage begins on the first day of the month following a new employee's completion of the probationary period established by the Employer.

Open Enrollment

If an employee elects not to enroll when first eligible to join the plan, they must wait until the next open enrollment period.

Continuation of Coverage

If an employer is subject to the provisions of the Age Discrimination in Employment Act (ADEA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or other applicable state law, coverage may be continued upon receipt of proper documentation.

Renewal and Termination

This dental policy is continued on an annual basis. The Company may terminate the policy at the end of the initial term, or any subsequent term, by giving written notice of at least 31 days to the policyholder. The policy can also be terminated for failure by the employer to pay premium, or to meet the minimum participation requirements of the policy.

10. 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.
11. for a condition covered under any Worker's Compensation Act or similar law.
12. that are applied toward satisfaction of a Deductible, if any.
13. that are generally considered by the dental profession as experimental or investigational.
14. for the treatment of cleft palate and anodontia.
15. for services or supplies payable under any medical expense plan.
16. for orthodontia, unless included by rider.
17. prior to the date the Insured is covered under the Policy.
18. for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD).
19. for hospital services.
20. for any unmarried child age 19 years of age and over unless he is dependent upon You for support, while a full-time student. A full-time student is one who is enrolled for 12 semester hours for credit in an accredited junior college, college or university. Any exception for a full-time student will end at age 23. This is subject to State requirements.
21. during any waiting period We require, when You voluntarily end Your insurance and re-enroll at a later date. Your waiting period is 2 years and begins on the date Your coverage first ended.
22. charges for infection control, sterilization, and waste disposal.

