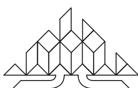
A Group Dental + Vision Plan at Competitive Group Rates

With State IIA-Endorsed Group Dental + Vision, You Get These Important Features

- ✔ Comprehensive preventive, basic and major dental coverage.
- ✔ Choice of either Dental + Vision or Dental Only insurance plans, so you can select the one that best meets your needs.
- ✔ Freedom to choose your own dentist and vision care provider.
- ✔ Automatic acceptance. No health statements are required.
- ✔ Economic pricing to give you maximum value for your insurance dollar.
- ✔ One-year initial rate guarantee.
- ✔ Available to State IIA Association firms with as few as 1 enrolling employee.

For State IIA Association Members



Administered by:
Kelsey National Corporation
3030 South Bundy Drive
Los Angeles, CA 90066

Security Life
INSURANCE COMPANY OF AMERICA

Underwritten by:
Security Life Insurance Co. of America
10901 Red Circle Drive
Minnetonka, MN 55343

Effective March 2005

An Overview of Your Plan Benefits

Dental Care Plan Benefits (Usual, Reasonable, Customary Expenses)		Benefit Coverage *1 - 99 Employees*
Preventive	Routine exams, consultations, teeth cleaning (2 every 12 months), full mouth x-rays (1 every 36 months), bitewing x-rays (2 every 12 months), topical fluoride (children, 1 every 12 months)	**80%** *No Deductible*
Basic	Oral surgery (extractions, impactions) Space maintainers (children under age 16) Fillings (firms of 5+) Fillings (firms of 1-4)	**80%** **80%** **80%** **50%**
Major	Crowns, inlays, bridges, dentures, root canal treatment, periodontics (12 month waiting period)* ($1,000 per insured Calendar Year Max.)	**50%**
Orhthodontic (optional)	Straightening of teeth (children under age 19) (***Mandatory 24-month waiting period***)*	**50%**
Deductible	Per Calendar Year	**$50** *per insured, or $150 per family*
Calendar Year Maximum Benefit (per insured)	Dental Orthodontic	**$1,500** **$500**
Lifetime Maximum Benefit (per insured)	Dental Orthodontic	**Unlimited** **$1,500**

Vision Care Plan Benefits (optional) *(Usual, Reasonable, Customary Expenses)*		Benefit Coverage *2 - 99 Employees*					
Vision Analysis	Complete analysis (1 every 12 months)	**100%** *Up to $50 per exam. No deductible.*					
Contact Lenses, Lenses and Frames (1 pair every 24 months)	Complete coverage with no deductible for:	**Up to these amounts:**					
		Lenses		**Frames**		**Total**	
	Single lenses + frames	$50	+	$50	=	$100	
	Bifocal lenses + frames	$50	+	$50	=	$100	
	Trifocal lenses + frames	$90	+	$50	=	$140	
	Lenticular lenses + frames	$100	+	$50	=	$150	
	Contact lenses					$100	

* For groups of 3 employees or more with existing and comparable Major Dental and/or Orthodontic coverage, insureds may receive credit for the time under their prior plan and apply it towards the total or partial satisfaction of the Major and/or Orthodontic waiting period.

Monthly Rates

IIA Dental + Vision + Ortho

1/1/2006 Rates

IIA Dental (no ortho, no vision)	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Employee	$19.59	$21.48	$23.60	$25.96	$28.56	$31.39	$34.46	$38.00
Ee + 1 Dependent	$36.74	$40.28	$44.26	$48.69	$53.55	$58.87	$64.62	$71.26
Ee + 2 Dependents	$55.85	$61.23	$67.29	$74.02	$81.42	$89.50	$98.24	$108.34

IIA Dental + Vision + Ortho

(Above Rates +)	IIA Vision Insurance Option	IIA Ortho Option
Employee	$2.82	Not Available
Ee + 1 Dependent	$5.36	$5.17
Ee + 2 Dependents	$8.04	$8.93

You may add the Ortho Option to either the Dental + Vision or Dental Only plan.

Initial Rate Guarantee: 12 months

Rating Areas 1/06

Find rating area using first 3 digits of employer ZIP code. Apply rating area rate for selected plan.

ZIP CODE TABLE

State	Area
Alabama	1
350-355, 359	3
Alaska	6
995-996	8
Arizona	1
856-857, 864	2
Arkansas	1
California	5
900-905	7
906-914	6
915-916	8
917-918	4
919-927	6
930-934	6
939	6
943-948	4
949	6
956-958	3
959	4
961	6
Colorado	1
803, 808-810	4
Delaware	2
District of Columbia	6
Georgia	1
300-303	2
Hawaii	3
Idaho	1
Illinois	1
600-605	2
606-608	3
Indiana	1
463-464	2
473	3
Iowa	1
Kansas	1
660-662	2
Kentucky	1
Louisiana	1
707-711	2
712	3

State	Area
Maryland	4
206-207, 209-211	2
217	3
Michigan	1
480-483	2
488-489	3
490-491	2
Minnesota	1
553-558, 564, 566	2
Mississippi	1
390-392	2
Missouri	1
640-641, 644-649	2
Montana	3
590-591	1
599	2
Nebraska	1
Nevada	4
890-891	2
894-895, 898	6
New Mexico	1
881	2
882	5
North Carolina	1
277	2
286	3
287-289	2
North Dakota	1
580-581	2
Ohio	1
Oklahoma	1
740-743	2
Oregon	2
977	3
978	1
Pennsylvania	1
170-178, 182-187	2
190-192	3
South Carolina	1
Tennessee	1
370, 373-374	2

State	Area
Texas	2
751-753	3
754	4
756-757, 776-777	1
Utah	1
Virginia	4
201, 220-221	5
222-223	6
224-225	1
228-229	2
230-232	1
233-237	5
240-244	2
Washington	5
982-984	4
990-992	3
993	6
West Virginia	2
255-257	4
262-265	3
Wisconsin	1
Wyoming	1

Not available in:
Connecticut
Florida
Maine
Massachusetts
New Hampshire
New Jersey
New York
Rhode Island
South Dakota
Vermont

Administrative Fees:
An installation fee of $12.65 is charged for each employee and each new employee added to the plan; $37.95 maximum in any one month. Monthly firm fee is $14.85 for firms of 1-3 insureds or $19.85 for firms of 4 or more insureds per premium statement, regardless of how many plans are included. **The installation fee is waived if the employer has another IIA Group Insurance Trust plan administered by Kelsey National Corporation.**

This is not a contract but is intended to provide a general description of the coverage. The actual policy should be consulted for complete details of policy provisions. Where state regulations vary from benefits, state regulations will apply. Cost and further details of coverage, including exceptions, reductions or limitations and the term under which the policies may be continued in force will be furnished by Kelsey National Corporation. Final acceptance of the group will be subject to approval by the carrier.

Fiduciary Liability and ERISA Bond Option
(Underwritten by American International Surplus Lines Insurance Co.)
Covers employer liability for errors and omissions in handling employee benefit plans to $1 million per loss with $1,000 deductible. Provides a $100,000 ERISA bond. Automatically issued unless waived on Employer Application. (See separate brochure for details.)

ELIGIBILITY AND REQUIREMENTS

Available to all firms that are active Independent Insurance Agents Association members: all active, full-time employees (working 30 hours or more per week); their legal spouses and unmarried children up to age 19 (or to age 25 if full-time students) not in the military. If both husband and wife are insured as employees, eligible children may be insured only as dependents of the principal wage earner.

Commission-only employees and independent contractors are also eligible and are included with all other eligible employees for participation requirements providing: actual commissions combined with any draw against commissions must equal at least 150 hours per month times the minimum wage, and the employer verifies full-time status (30 or more hours per week) with the participating firm to Kelsey National Corporation.

Also available to full-time employees who work for divisions, subsidiaries, etc., affiliated through common ownership such as real estate, banking, mortgage lenders or escrow firms.

Covers mentally or physically handicapped children over age 19, provided child remains handicapped, dependent on the Insured for support and Insured notifies the Insurance Company in writing within 31 days after child reaches termination age.

New employees are eligible on the first day of the month following the 1-2-or-3 month waiting period selected by the employer. If any enrollment card is received for an employee or dependent more than 30 days after becoming eligible, a 24-month waiting period for major service benefits will apply.

Enrollment simply requires an Employer Application and completed Enrollment Forms for all eligible employees. The firm's effective date will be the first day of the month per the firm's request. The application must be postmarked by the requested effective date. Final acceptance of the group is subject to approval by the carrier.

Participation

Employee participation must equal 100% if employer pays entire employee premium. Alternatively, if the plan is contributory then the following applies:

Eligible Employees	Participation Requirements
1-5	100%
6-7	All but 1
8+	75% eligible

If dependent coverage is selected, at least 50% of insured employees with dependents must insure their dependents.

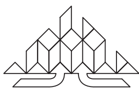
JOINDER AGREEMENT

TO THE TRUSTEE OF THE INDEPENDENT INSURANCE AGENTS GROUP INSURANCE TRUST FUND:

The signee, a member of an Independent Insurance Agents Association, hereby requests the Trustee of the Independent Insurance Agents Group Insurance Trust Fund to enroll our firm as a participating employer for a plan of group insurance covering eligible employees of the firm applying.

The signee hereby subscribes to the Trust Agreement dated the 22nd day of September, 1988, as amended, and agrees to be bound by the terms and conditions thereof. A copy of said Trust Agreement will be made available to the subscribers upon written request. Kelsey National Corporation receives commission of 2 1/2% for acting as agent and a fee from the Trust for services rendered managing it.

The signee hereby acknowledges that the Trustee of the Independent Insurance Agents Group Insurance Trust Fund in seeking to obtain and keep in force such group insurance, does so as a matter of accommodation only. The participating employer agrees to be bound by the terms of the master policy and in return for benefits provided thereunder guarantees prompt payment of premiums due. The Trustee is merely a holder of the master policy, whose responsibility is to issue certificates to participating employees and to collect premiums, but the insurance agreement and all claims arising thereunder are purely a matter between the signee and the insurance carrier.



All completed Enrollment Forms should be sent by the employer to:
Kelsey National Corporation
3030 South Bundy Drive
Los Angeles, CA 90066

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Underwritten by:
Security Life Insurance Co. of America
10901 Red Circle Drive
Minnetonka, MN 55343

STATE IIA ASSOCIATION DENTAL + VISION EMPLOYER APPLICATION

FIRM INFORMATION

Firm Name: ______________________________

Street address: ______________________________

City ______________________________ State __________ ZIP __________

Phone (_____) ______________________________ FAX (_____) ______________________________

Individual to contact for routine information: ______________________________

Email ______________________________

Individual to contact for special information: ______________________________

Email ______________________________

FIRM QUESTIONAIRE

1. Our firm has chosen a . . . . ❏ 1 month ❏ 2 month ❏ 3 month New Employee Waiting Period
2. Our firm is a . . . . ❏ Sole Owner ❏ Partnership ❏ Corporation
3. Our firm has chosen the . . . . . . ❏ Dental + Vision ❏ Dental Only
   ❏ Orthodontic Option *(Can be added to either the Dental + Vision, or Dental Only Plan)*
4. We certify that the total number of full-time eligible employees (including owners & partners) is ____________ of which the total number enrolled is _________ individuals and _________ dependents.
5. Our firm pays the following portion of Premiums: Employee ___________% Dependent ___________%
6. We would like the insurance to become effective on ____________________, 20______. We understand that you will confirm an effective date and bill us later.
   Note: Your requested effective date may not be your actual effective date.
7. Our firm is enrolled in another group plan administered by Kelsey National Corporation. . . . . . ❏ Yes ❏ No
   (If "Yes") Our account number is: ______________________

TO COMPLETE YOUR ENROLLMENT STEPS BE SURE TO COMPLETE THE CHECKLIST BELOW:

❏ We have completed this Employer Application. This form constitutes application by your firm for participation in the State IIA Association Group Dental + Vision Plan or Dental Only Plan. This form should be signed by the owner, a partner or a corporate officer.

❏ We have distributed enrollment APPLICATIONS to all eligible employees. All full-time employees including owner, partners, officers, agents, brokers, solicitors, etc. who work 30 hours or more per week at your firm are eligible. Applications should be signed by all eligible employees whether or not they wish to enroll. *(Note: Please make sure your firm meets the minimum participation requirements listed under the eligibility & requirements section.)*

❏ Please indicate the number of Enrollment Applications you are returning with your Employer Application: ___________ (There should be one for each eligible employee.)

❏ Completed applications should be mailed to:

IIA Group Insurance Trust
Kelsey National Corporation
3030 S. Bundy Dr.
Los Angeles, CA 90066

Fiduciary Liability and ERISA Bond Option: Fiduciary liability and ERISA bond coverage is automatically included unless already in force or waived by applicant initialing here _________ (not available in Kentucky).

IMPORTANT: *Send no money at this time. You will receive written acceptance from the IIA Group Insurance Trust and an itemized premium statement showing individual monthly premiums and an administration fee, which covers all group plans included on the premium statement.*

Member firm name: ______________________________ Date: ______________________________

Signature: X ______________________________ Title: ______________________________

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IIA Group Insurance Trust

Dental + Vision Employee Enrollment Application

Employees you wish to add to the plan must complete the employer, employee and family information section below and sign and date the enrollment form. Employees refusing or discontinuing coverage under this plan must complete the employer, employee and refusal or discontinuance of coverage section.

EMPLOYER SECTION

Please check one box only: ❏ Initial Request ❏ Request for a Change	Firm Name:	
	Firm Phone:	Account #:

EMPLOYEE SECTION *(Please print all information, sign and date)*

Employee's Name: (last) (first) (initial)			SS#:
Home Address: (street) (city) (state) (zip)			
Date of Birth:	Age:	Date Employed:	Sex: ❏ Male ❏ Female
Email Address:			
Job Title:			

FAMILY INFORMATION

Please choose one:
❏ Married
❏ Not Married

I want to Insure:
a. Employee Only . . . . ❏ Yes ❏ No
b. Employee + 1 Dependent . . . . ❏ Yes ❏ No
a. Employee + 2 or more Dependents . . . . ❏ Yes ❏ No

LIST OF DEPENDENT NAMES AND BIRTH DATES

DEPENDENT NAME	BIRTH DATE
1.	
2.	
3.	
4.	
5.	

All dependent children listed above over age 18 are full-time students: . . . . ❏ Yes ❏ No
If No, who is not? ____

Do you claim a tax exemption for all eligible dependents listed above? . . . . ❏ Yes ❏ No
If No, who not? ____

PLEASE SIGN AND DATE HERE

I hereby declare that I am an active full-time employee of the employer indicated above and that I regularly work at least 30 hours per week at or from the employment location indicated. I hereby request the group insurance for which I am or may become eligible under the policies issued to the Trustee of the Independent Insurance Agents Group Insurance Trust by the Insurance Company. I authorize the deductions from my earnings of any contributions I may have to make toward the cost. I understand that my request shall include this form. All information given by me on this form is true and complete and is offered as an inducement to grant insurance.

Dated this ________ day of ________________ 20_______ Signature of Applicant ***X***______________________________________

Coverage provided by Delta Dental

REFUSAL OR DISCONTINUANCE OF COVERAGE

1. a. ❏ I hereby decline Group Coverage described further in Section 2 below.
   b. ❏ I hereby request discontinuance of the Group Coverage described further in Section 2 below, effective on ____________________

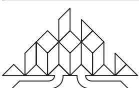
2. Applies to: ❏ My coverage ❏ My spouse's coverage ❏ My children's coverage

3. Reason for refusal: ❏ Covered under a Military Insurance Plan
   ❏ Covered under spouse's Employer Group Insurance Plan with
   (Name of Insurer and/or Employer): ____
   ❏ Other (Specify):____

I understand that if I later wish to enroll or re-enroll in the Plans, I will be subject to late entrant provisions of the plan.

Employee's Signature **X** ____ Date ____________________

Name of Employer Firm ____



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LIMITATIONS AND EXCLUSIONS

ELIGIBLE EXPENSES

Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To be an Eligible Dental Expense, the services must be performed by: (a) a licensed Dentist acting within the scope of his license; or (b) a licensed Physician performing dental services within the scope of his license; or (c) a licensed Dental Hygienist acting under the supervision and direction of a Dentist. To be an Eligible Vision Expense, services must be performed by a legally qualified (a) Opthalmologist (MD) (b) Optometrist (OD) (c) or Dispensing Optician acting within the scope of their license.

COVERED ELIGIBLE EXPENSES

This plan reimburses for usual, reasonable and customary expenses as determined by the Insurance Company while insured for eligible covered procedures. If two or more procedures are suitable for correction of a specific condition, plan will pay usual, reasonable and customary charges for the least expensive procedure.

EXPENSES INCURRED

An Eligible Expense is considered incurred on the following dates: on the date final impression is taken for full and partial dentures; the date teeth are first prepared for fixed bridges, crowns, inlays, and onlays; the date the pulp chamber is opened for root canal therapy; the date periodontal surgery is performed; the date appliances or bands are inserted or a one-step procedure is performed for orthodontic services; on the date the service is performed for all other services. If coverage is terminated, insurance will be extended to cover these expenses provided they were incurred within 30 days immediately following termination. All other expenses are considered incurred at the time service is rendered or a supply is furnished.

Vision care is covered on a usual, reasonable and customary basis up to amounts listed for: lenses prescribed and visual analysis performed by a legally qualified opthalmologist or optometrist, replacement of lenses when required by prescription change and replacement of frames when existing frames are no longer compatible with new lenses.

The calendar year dental deductible is $50 per person, with a $150 family maximum deductible. Dental expenses that were applied toward the individual or family deductible during the last three months of a calendar year will be applied toward the next year's deductible. There is no deductible on vision benefits.

EXPENSES NOT COVERED

No benefits will be paid for expenses incurred: • for any procedure not considered an Eligible Expense, necessary or usual and customary for the treatment of the condition; for any portion of a charge in excess of the prevailing fee; for crowns, inlays or onlays for teeth that can be (a) restored by other means, (b) periodontal splinting (c) correction of abrasion or erosion; for procedures relating to (a) the change of vertical dimension (b) restoration of occlusion (c) bite registration (d) bite analysis; overdentures and associated procedures; cosmetic purposes; initial placement of full and partial dentures or bridges that include the replacement of natural teeth that are (a) congenitally missing (b) lost before coverage began (c) lost while covered if replacement occurs after a break in coverage or more than 12 months after loss of the teeth; replacement of full and partial dentures, bridges, inlays, onlays and crowns (a) during the first 24 months of coverage under the policy or (b) replacement is within 5 years of the last replacement (c) that can be repaired and restored to natural function; • for implants and for (a) replacement of lost or stolen appliances (b) replacement of orthodontic retainers (c) myofunctional therapy (d) athletic mouthguards (e) precision or semi-precision attachments (f) denture duplication (g) sealants (h) treatment of fractures or cysts (i) orthognathic surgery (j) temporormandibular joint (TMJ) dysfunctions; for oral hygiene instruction and (a) plaque control (b) completion of claim forms (c) acid etch (d) broken appointments (e) prescription or take-home fluoride (f) diagnostic photographs; hospital expenses and related anesthetic expenses; services not completed by the end of the month in which coverage ends; procedures started, but not completed; applied toward satisfaction of Deductibles, if any; for services that, in Our opinion do not have a reasonable favorable prognosis; expenses payable under any medical plan provided by Your employer; procedures (a) performed by a member of Your immediate family (b) rendered at no charge, in absence of insurance; procedures in connection with (a) war or any act of war, whether declared or undeclared or (b) condition contracted or (c) accident occurring while on full-time active duty in the armed forces of any country or combination of countries; care or treatment of a condition when a person is entitled to or eligible for benefits under any Workers Compensation Act or similar law for a lens in excess of standard lens that fits a frame with an eye size of less than 56mm; replacement lenses, unless there is a change in prescription; replacement frames, unless the existing frame is not compatible with the replacement lens; replacement of lost or broken (a) lenses, (b) frames; orthoptics; vision training; subnormal or other special purpose vision aids; plano or prescription sunglasses; medical or surgical treatment of the eyes, including hospital expenses; duplicate (a) glasses, (b) lenses, (c) frames; services or material not listed as an Eligible Vision Expense.

ALTERNATE BENEFITS

If (1) We determine a less expensive alternate procedure, service or course of treatment can be performed in place of the proposed treatment to correct the dental condition; and (2) the alternate treatment will produce a professionally satisfactory result, then the maximum Eligible Expense We will allow will be the charge for the less expensive treatment.

COORDINATION OF BENEFITS

Coordination will apply in determining benefits payable for any Claim Period if the sum of (1) benefits that would be payable under this Plan in the absence of coordination and (2) the benefits that would be payable under all other Plans in the absence of provisions for coordination in those Plans would exceed those Eligible Expenses.

TERMINATION OF COVERAGE

Coverage will end automatically on the earliest of (a) the last day of the month in which you cease to be eligible (b) the last day of the month for which required premium has been paid (c) the date your employer ends participation under the policy (d) the date the policy is terminated or discontinued.