

# A Group Dental Plan

at economical  
group rates



KELSEY NATIONAL  
CORPORATION



## With State IIA Endorsed Group Dental, You Get These Important Features

- ✓ **Comprehensive** preventive, basic and major dental coverage.
- ✓ **Choice of plans...** so you can select the one that best meets your needs.
- ✓ You **choose your own dentist and dental specialists.**
- ✓ This plan is **guaranteed issue.** No health statements are required!
- ✓ **Economically priced** to give you maximum value for your insurance dollar.
- ✓ Available to State IIA Association firms with **as few as 2** enrolling employees.

**For State IIA  
Association Members**

Effective July, 2001

Underwritten by The United States Life Insurance Company, rated A+ (Superior)) by A.M. Best Company for financial stability.

# Choose the Dental Plan that Best Meets Your Needs.

## Here are Your Plan Benefits

Dental Care Plan Benefits <i>(Usual, Reasonable, Customary Expenses)</i>		PLAN I	PLAN II	PLAN III
<b>Preventive</b>	Routine exams, teeth cleaning (1 every 6 months), full mouth X-rays (1 every 48 months), bitewing X-rays (4 films every 6 months), topical fluoride (children under 18, 1 every 6 months), space maintainers (children under 16 & limited to initial appliance only.)	100%	100%	100%
<b>Basic</b>	Consultations (1 every 12 months), Fillings, oral surgery (extractions, impactions).	80%	80%	80%
<b>Major</b>	Crowns, inlays, bridges, dentures, periodontics root canal treatment (12 month waiting period).	50%	50%	0%
<b>Deductible</b>	Per Calendar Year (Limit of three deductibles per family.)	\$50 <sup>*</sup>	\$100	\$50 <sup>†</sup>
<b>Calendar Year Maximum Benefit (per insured)</b>	Dental	\$1,000 or \$1,500	\$1,000 or \$1,500	\$1,000

**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.**

\* Deductible may be waived for Preventive or applied to all three areas of service (Preventive, Basic, Major).

† Deductible may be waived for Preventive only.

### Covered Eligible Expenses

Pays usual, reasonable and customary expenses as determined by the Insurance Company while insured for 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 are considered incurred on the date when: master impression is made for prosthetic device; when teeth are prepared for crown, bridge or cast restoration; and when pulp chamber is opened for root canal therapy. If coverage is terminated, insurance will be extended to cover these expenses provided they

were incurred within 31 days immediately following termination. All other expenses are considered incurred at the time service is rendered or a supply is furnished.

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.

### Coordination of Benefits

If benefits provided under this plan and another plan exceed actual dental expenses incurred, the combined benefits payable will not exceed "allowable expenses".

## Eligibility and Enrollment

Available to all firms of 2-24 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 and other late entrants are eligible on the first day of the month following the 1, 2, or 3 month waiting period selected by the employer. (A late entrant is any person who becomes insured more than 31 days after becoming eligible or becomes insured again after his insurance ended due to non-payment of premium.) Once a late entrant becomes insured, the plan will pay covered Preventive services immediately; covered Basic services after 6 months; and covered Major services after 12 months. These waiting periods will be waived if eligible employees or dependents who initially waived coverage because they had coverage elsewhere now enroll because that coverage has terminated. Proof of prior coverage with the enrollment form is required.

Enrollment simply requires an Employer Application and completed enrollment cards 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 Insurance Company.

## Participation

75% of all eligible employees and their dependents must enroll. Eligible employees are those not covered under any other group dental insurance plan. The employer must contribute at least 35% towards the premium. Waiver cards must be completed for those waiving coverage.

## Rate Information

For current rate information, please contact Kelsey National for a FREE QUOTE.

## CHARGES NOT COVERED

Charges for the following services or devices will not be covered:

- Oral hygiene, plaque control, diet instruction
- Topical sealants
- Precision attachments
- Treatment which: does not meet accepted standards of dental practice; is experimental in nature; or is due to: (a) an on-the-job related injury; or (b) a condition for which benefits are payable by Workers Compensation or similar laws.
- Orthodontic treatment
- Appliances or prosthetic devices used to: change vertical dimension; restore or maintain occlusion, except to the extent that this benefit section covers orthodontic benefits; splint or stabilize teeth for periodontic reasons; replace tooth structure lost as a result of abrasion or attrition; and treat disturbances of the temporomandibular joint.
- Cosmetic services including but not limited to: characterizing and personalizing prosthetic devices; or making facings on prosthetic devices for any tooth posterior to the second bicuspid.
- Replacement of an appliance or prosthetic device unless; the appliance or device is at least 10 years old and cannot be made usable; or the appliance or device is damaged, while in the insured person's mouth in an injury which occurs while insured, and it cannot be repaired.
- Replacement crowns within 5 years of initial placement.
- Replacement of a lost, stolen or missing appliance or prosthetic device
- Replacement of a lost, stolen or missing appliance or prosthetic device.
- Making a spare appliance or device
- Services or devices for which no charge is made, including but not limited to: the covered persons employer, labor union or similar group, in its dental or medical department or clinic; a facility owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body.
- For surgery, periodontic or endodontic treatment, we will not pay separately for: x-rays; the treatment plan; local anesthetics; or routine follow-up care
- Diagnostic casts
- Implants
- Radical resection of mandible with bone graft.

*This is a summary of benefits only and is subject to the terms, conditions and limitations of the actual Group Policy. 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 an American International Surplus Lines Insurance Company

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).

# State IIA Association Dental Employer Application

Introducing...an employer application that makes it easy to say "YES"  
to State IIA Endorsed Group Coverage!

**YES!** I am ready to enroll in State IIA Endorsed Dental Group Coverage to receive the following benefits.

	<input type="radio"/> <b>Plan I</b>	<input type="radio"/> <b>Plan II</b>	<input type="radio"/> <b>Plan III</b>
Deductible Waived for Preventive:	<input type="radio"/> No <input type="radio"/> Yes	<input checked="" type="radio"/> No	<input type="radio"/> No <input type="radio"/> Yes
Annual Maximum:	<input type="radio"/> \$1,000 <input type="radio"/> \$1,500	<input type="radio"/> \$1,000 <input type="radio"/> \$1,500	<input checked="" type="radio"/> \$1,000

**YES!** Our firm has chosen a     1       2       3 month New Employee Waiting Period

**YES!** Our firm is a successful     Sole Owner     Partnership     Corporation

## YES! Our firm information is as follows:

Firm Name _____			
Street address: _____			
	City	State	ZIP
Phone: _____		FAX: _____	
Affiliates or Subsidiaries to be covered:			
Street address: _____			
	City	State	ZIP
Phone: _____		FAX: _____	
Individual to contact for routine information: _____			
Email: _____			
Individual to contact for special information: _____			
Email: _____			

**YES!** We certify that the total number of full-time, eligible employees (between 2 & 24 including owners, partners, etc.) is \_\_\_\_\_ of which the total number enrolled is \_\_\_\_\_ individuals with \_\_\_\_\_ dependents.

**YES!** Our firm's plan will be:

Non Contributory - employees will not contribute toward the cost of insurance.

Contributory - employees will pay the following percentage of the cost of insurance:  
Dental: \_\_\_\_\_ % for Employee and \_\_\_\_\_ % for Dependents

**YES!** Our firm is and has been a member of the Independent Insurance Agents Association for  
 Less than 3 months     3-12 months     \_\_\_\_\_ years

**YES!** We would like the insurance to become effective on \_\_\_\_\_, 200\_\_\_\_ and we understand that you will confirm an effective date and bill us later.

**Please Complete**

1. Indicate the number of enrollment cards you are returning with your application: \_\_\_\_\_  
(There should be one for each eligible employee.)
2. On the date this application is signed, has any employee been out of work for 5 or more consecutive work days due to illness, injury, or maternity?     Yes       No
3. Provide a list of persons being continued due to a continuation of insurance, extension of benefits, or like provision, as provided by state or federal law.

Name	Date Continuation Began	Qualifying Event
_____	_____	_____
_____	_____	_____
_____	_____	_____

# Enrollment Instructions

To complete your enrollment steps be sure to confirm:

- YES!** We have completed this **EMPLOYER APPLICATION**.  
This form constitutes application by your firm for participation in the State IIA Association Group Dental Plan. The form should be signed by the owner, a partner or a corporate officer.
- YES!** We have distributed **ENROLLMENT FORMS** to all eligible employees.  
All full-time employees including owner, partners, officers, agents, brokers, solicitors, etc. who are actively at work 30 hours or more per week at your firm and performs his/her job for full pay are eligible. The forms should be signed by all eligible employees whether or not they wish to enroll.

## Important: Send No Money At This Time

You will conveniently be billed later.

## Participation

For non-contributory plans all employees and dependents must enroll. For contributory plans at least 75% of all eligible employees and their dependents must enroll. Eligible employees are those not covered under any other group dental insurance plan. The employer must contribute at least 35% towards premium. The Refusal Section of the Employee Enrollment Form must be completed for those waiving coverage.

## 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.

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.

### Please Complete and Sign

- Our firm has been enrolled in a prior Dental plan. We have enclosed a copy of our prior plan's last monthly statement and a plan brochure or certificate.
- Our firm is enrolled in another group plan administered by Trust Administration Services.

Our account number is: \_\_\_\_\_

**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).**

Member firm name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: **X** \_\_\_\_\_ Title \_\_\_\_\_  
(Owner, partner or corporate officer)

### Dental Plan underwritten by The United States Life Insurance Company

Fiduciary Liability & ERISA Bond option underwritten by American Surplus Lines Insurance Company.

All completed applications should be sent to:  
**KELSEY NATIONAL CORPORATION**  
3030 South Bundy Drive  
Los Angeles, CA 90066

Underwritten by:

**The United States Life Insurance Company In the City of New York**  
*Member American General Financial Group*

Rated A+ (Superior) by A. M. Best & Company

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