E-Z PAY OPTIONS FOR
M.N.E.A Dental Plans

1. Please indicate which plan you choose:_____***OPTION I M.N.E.A DHMO PLAN**
   *The dental application must accompany this form _____***OPTION II M.N.E.A INDEMNITY PLAN**

2. Please select your preferred payment method below.

PLEASE PLACE CHECK MARK BY DESIRED PAYMENT OPTION:

____ I wish to pay a **one time annual fee by check** (payable to Dental Source)

____ I wish to pay **a one time annual fee by credit Card**

___ I wish to **pay monthly by Bank Draft** *(must include 1st months premium with a voided check of the account to be drafted on a monthly basis)*

Checking:
Bank Name_____
Attach only a void check, bank letter or specification sheet. Deposit Tickets not accepted.

Annual Payment by Credit Card:
Card Type ____VISA ___ MASTERCARD ___DISCOVER

Card# __ __ __ __-__ __ __ __-__ __ __ __-__ __ __ __

Expiration Date ___/___ Signature_____ Date_____

(Your enrollment is for one year. You will receive notification once your application is processed. If you chose the Dental Source plan please make sure you selected a dentist from the list and listed your selection on the enrollment form)

Mail this form and the enrollment form to:
12946 Dairy Ashford, Ste. 360 Sugarland, TX. 77478

Dental Source

Dental Health Care Plans

Schedule of Benefits – Plan E

The American Dental Association (ADA) assigns code numbers to each dental service. The Schedule of Services below provides you with an easy reference to the coverage associated with the Dental Source Program. All co payments are paid directly to your selected participating general dentist and are due at the time of service. All dental services listed in this schedule are provided **exclusively** by Dental Source network general dentists. There is no coverage outside of the Dental Source network. If the services of a Specialist are required, the member will receive a 20% discount off the usual fees from a participating Specialist, where available.

ADA CODE	PROCEDURE	Copayment
	Diagnostic and Preventive – General Dentists Office	
****	Consultation	No Charge
0120	Periodic Oral Examination	No Charge
0140	Limited Oral Evaluation-Problem Focused	No Charge
0150	Comprehensive Oral Evaluation	No Charge
0160	Detailed & Extensive Oral Evaluation	No Charge
0210	Full Mouth X-Ray (Once Every 5 Years)	No Charge
0220	Initial Periapical X-Ray	No Charge
0230	Additional Periapical X-Ray	No Charge
0240	Occlusal X-Ray	No Charge
0250-60	Extraoral X-Ray	No Charge
0270-77	Bitewing X-Ray	No Charge
0330	Panoramic X-Ray (Once Every 5 Years)	No Charge
0460	Tooth Pulp Vitality Test	No Charge
0470	Diagnostic Casts - Study Models	No Charge
1110	Prophylaxis-Adult-Every 6 Months*	No Charge
1120	Prophylaxis-Child-Every 6 Months*	No Charge
1203	Topical Application of Fluoride-Child-Every 6 Months	No Charge
1330	Oral Hygiene Instruction	No Charge
1351	Sealant	50%
1510	Space Maintainer-Fixed-Unilateral	50%
1515	Space Maintainer-Fixed-Bilateral	50%
1520	Space Maintainer-Removable-Unilateral	50%
1525	Space Maintainer-Removable-Bilateral	50%
****	Difficult prophylaxis may be subject to a $20.00 charge.	
	Restorative (Fillings, Inlays and Onlays) - General Dentist Office	
2140	Amalgam- One Surface Primary or Permanent	30%
2150	Amalgam- Two Surfaces Primary or Permanent	30%
2160	Amalgam- Three Surfaces Primary or Permanent	30%
2161	Amalgam- Four or More Surfaces Primary or Permanent	30%
2210	Silicate Cement-Per Restoration	50%
2330-35	Resin-Based Composite- 1, 2, 3 or 4 Surfaces, Anterior	30%
2390	Resin-Based Composite Crown, Anterior	50%
2391-94	Resin-Based Composite 1 or More Surface-Posterior-**Primary**	30%
2391-94	Resin-Based Composite-Posterior **Permanent**	70%
2410-30	Gold Foil-1, 2 or 3 Surfaces	50%
2510-30	Inlay-Metallic-1, 2, 3 or More Surfaces	50%
2542-44	Onlay-Metallic-2,3 or 4 Surfaces	50%
2610-30	Inlay-Porcelain/Ceramic1, 2,3 or More Surfaces	50%
2642-44	Onlay-Porcelain/Ceramic 1, 2, 3 or More Surfaces	50%
2650-52	Inlay- Resin-Based Composite -1, 2, 3 or More Surfaces	50%
2662	Onlay-Resin-Based Composite-2, 3, 4 or More Surfaces	50%
2664	Onlay-Composite/Resin-4 or more Surface/Lab Process	50%
2940	Sedative Fillings	30%
****	Laboratory Fees are Not Covered by the Dental Source Plan	
	Restorative (Crowns-Single Restorations) - General Dentist Office	
****	Crown-Temporary in Conjunction With Permanent	No Charge
2710	Crown-Resin (Indirect)	50%
2720	Crown-Resin with High Noble Metal	50%
2721	Crown-Resin with Predominantly Base Metal	50%
2722	Crown-Resin with Noble Metal	50%
2740	Crown-Porcelain/Ceramic Substrate	50%
2750	Crown-Porcelain Fused to High Noble Metal	50%
2751	Crown-Porcelain Fused to Predominantly Base Metal	50%
2752	Crown-Porcelain Fused to Noble Metal	50%
2780-83	Crown-3/4	50%
2790	Crown-Full Cast High Noble Metal	50%
2791	Crown-Full Cast Predominantly Base Metal	50%
2792	Crown-Full Cast Noble Metal	50%
2910	Recement Inlay	50%
2920	Recement Crown	50%
2950	Core Buildup, Including Any Pins	50%
2951	Pin Retention per Tooth, in Addition to Restoration	50%
2952	Cast Post & Core in Addition to Crown	50%
2953	Cast Post as Part of Crown Same Tooth	50%
2954	Pre-fab Post & Core in Addition to Crown	50%
2960	Labial Veneers (Resin Laminate) Chairside	60%
2961	Labial Veneers (Resin Laminate) Laboratory	60%
2962	Labial Veneers (Porcelain Laminate) Laboratory	60%
2980	Crown Repair - By Report	50%
	Endodontics (Root Canal Therapy) - General Dentist Office	
****	Endo Consultation	No Charge
3110	Pulp Cap Direct	50%
3120	Pulp Cap Indirect	50%
3220	Vital Pulpotomy	50%
3310	Root Canal-Anterior	50%
3320	Root Canal-Bicuspid	50%
3330	Root Canal-Molar	50%
3340	Root Canal-Four Canals	50%
3410-26	Apicoectomy	50%
9974	Internal Bleaching after Endodontic Treatment	60%
	Periodontics - General Dentist Office	
****	Perio Consultation	No Charge
0180	Comprehensive Perio Examination	60%
4210	Gingivectomy or Gingivoplasty (per quadrant)	60%
4211	Gingivectomy or Gingivoplasty (1 to 3 teeth per quadrant)	60%
4220	Gingival Curettage (per quadrant)	60%
4240	Gingival Flap Surgery (per quadrant)	60%
4241	Gingival Flap Surgery (1 to 3 teeth per quadrant)	60%
4260	Osseous Surgery (per quadrant)	60%
4261	Osseous Surgery (1 to 3 teeth per quadrant)	60%
4263	Bone Replacement Graft-First Site in Quadrant	60%
4264	Bone Replacement Graft-Each Additional Site	60%
4270	Pedicle Soft Tissue Graft Procedure	60%
4271	Free Soft Tissue Graft (Including Donor Site)	60%
4341	Periodontal scaling & root planing (per quadrant)	60%
4342	Periodontal scaling & root planing(1 to 3 teeth per quadrant)	60%
4355	Full mouth debridement	60%
	Prosthodontics (Removable) - General Dentist Office	
5110	Complete Dentures-Upper	50%
5120	Complete Dentures-Lower	50%
5130	Immediate Upper Denture	50%
5140	Immediate Lower Denture	50%
5211	Partial Denture-Upper/Resin Base	50%
5212	Partial Denture-Lower/Resin Base	50%
5213	Partial Denture-Upper/Cast Metal Framework/Resin Base	50%
5214	Partial Denture-Lower/Cast Metal Framework/Resin Base	50%
5730-31	Reline Upper/Lower Complete Denture Chairside	50%
5740-41	Reline Upper/Lower Partial Denture Chairside	50%
5750-51	Reline Upper/Lower Complete Denture (Lab)	50%
5760-61	Reline Upper/Lower Partial Denture (Lab)	50%
5810	Interim Complete Denture-Upper	50%
5811	Interim Complete Denture-Lower	50%
5820	Interim Partial Denture-Upper	50%

5821	Interim Partial Denture-Lower	50%
****	All other denture and partial related procedures	50%
****	Laboratory Fees are Not Covered by the Dental Source Plan	

Prosthodontics - General Dentist Office

6240	Pontic-Porcelain Fused to High Noble Metal	50%
6241	Pontic-Porcelain Fused to Predominantly Base Metal	50%
6242	Pontic-Porcelain Fused to Noble Metal	50%
6750	Crown-Porcelain Fused to High Noble Metal	50%
6751	Crown-Porcelain Fused to Predominantly Base Metal	50%
6752	Crown-Porcelain Fused to Noble Metal	50%
6790	Crown-Full Cast High Noble Metal	50%
6791	Crown-Full Cast Predominantly Base Metal	50%
6792	Crown-Full Cast Noble Metal	50%
6930	Recement Bridge	50%
****	Laboratory Fees are Not Covered by the Dental Source Plan.	

Oral Surgery - General Dentist Office

****	Oral Surgery Consultation	No Charge
7111	Extraction-Coronal Remnants-Primary	50%
7140	Extraction-Erupted Tooth or Exposed Root	50%
7210	Surgical Removal of Erupted Tooth	75%
7220	Removal of Impacted Tooth-Soft Tissue	75%
7230	Removal of Impacted Tooth-Partial Bony	75%
7240	Removal of Impacted Tooth-Complete Bony	75%
7310	Alveopolasty in Conjunction with Extractions/Per Quadrant	50%
7320	Alveoloplasty Not in Conjunction with Extractions Per Quadrant	50%
7470	Removal of Exostosis	50%
7510	Incision & Drainage of Abscess-Intraoral	50%
7520	Incision & Drainage of Abscess-Extraoral	50%
7960	Frenectomy	50%
****	Post Operative Treatment (including dry socket treatment)	No Charge

Orthodontics (Braces) - General Dentist Office

****	Ortho Consultation (at General Dentist Only)	No Charge
****	Ortho Treatment Plan (Records & Models)	75%
****	Orthodontic Appliance	75%
****	Orthodontic Appliance Therapy	75%
****	Orthodontic Treatment	75%

Adjunctive General Services - General Dentist Office

9110	Palliative Treatment (Normal Office Hours)	$15.00
9215	Local Anesthesia	No Charge
9430	Office Visits For Observation (Normal Office Hours)	No Charge
9440	Emergency office visit (After Office Hours)	$25.00
9450	Treatment Plan Presentation	No Charge
9940	Occlusal Guards-By Report	60%
9951	Occlusal Adjustment- Limited	60%
9952	Occlusal Adjustment- Complete	60%
9999	Broken Appointments are subject to a $10.00 charge for each 15 minutes of scheduled time	

EMERGENCY TREATMENT COVERAGE:

In the event of a dental emergency, Dental Source members should contact their selected Dental Source provider. If the Dental Source provider is unavailable for emergency care within 24 hours, members may obtain emergency services from any licensed dentist. The covered emergency services include palliative treatment to control pain, bleeding, or infection. Dental Source members can be reimbursed up to $50.00-based on the Dental Source Schedule of benefits. The member's selected Dental Source provider must provide any further restorative service. In order to receive reimbursement for fees paid, less any applicable copayment, the member must notify Dental Source within two working days of the onset of the emergency, and written request for reimbursement with receipts must be received by Dental Source within 30 days of the onset of the emergency.

EXCLUSIONS AND LIMITATIONS - GENERAL DENTIST

1. Laboratory fees or lab related charges.
2. Prophylaxis (cleanings) and fluoride treatments are limited to one every 6 months. Difficult prophylaxis (i.e. heavy smoker, very neglected teeth) is subject to a $20.00 charge.
3. Procedures provided by any dentists including specialists who are not within the Dental Source provider network.
4. Procedures provided by a participating Dental Source dentist other than your selected dentist prior to receiving approval from the Dental Source office.
5. Procedures or dental expenses incurred in connection with any dental procedure started prior to the member's eligibility or in progress at the time of application.
Dental expenses incurred if a participating dentist is unable to perform a procedure due to a member's general health or physical condition (i.e. patient physically unable to visit dentist office or suffering from a contagious illness or disease).
6. Dental expenses incurred after termination of eligibility.
7. Charges for broken appointments.
8. Any dental procedure not listed as a covered service including but not limited to general anesthesia, the services of an anesthesiologist, prescription medication, nitrous oxide, implants, treatment required by reason of war, hospital and medical charges of any kind, surgery of fractures and dislocations, loss or theft of dentures or bridgework, and the treatment of malignancies.
9. Services that are provided to the member by state government, or agencies thereof, or services provided without cost to the member by any municipality, county, or other subdivision.
10. Procedures, appliances, or restorations to correct congenital, developmental, or medically induced dental disorders, including but not limited to, treatment of myo-functional, myo-skeletal, or temporomandibular joint dysfunction (TMJ).
11. Dentures, bridges, and other appliances installed under this program can be replaced only once during the period of 5 years after the original installation. A denture, crown, bridge, or other appliance can be replaced only if it cannot be made satisfactory by reline or repair.
12. A denture, bridge, or other appliance installed while not covered by Dental Source will be replaced only if it cannot be made satisfactory by reline or repair.
13. All covered replacements are subject to the copayment percentages as listed in the Schedule of Services.
14. Crowns are covered only if the dentist determines that there is not enough retentive quality left in a tooth to hold a filling.
15. Replacement of a satisfactory filling is not covered.
16. Charges for office sterilization.
17. Fluoride treatments are limited to once every 6 months to age 19.
18. Any dental procedure solely for the purpose of cosmetic reasons is not a covered benefit.
19. Sealants covered through age 15, replaced at no charge within 12 months of original application.
20. A dependent child shall be covered until the age of 25; if unmarried, a state resident and not covered under another benefit plan or government program.

THIS FEE SCHEDULE IS ONLY APPLICABLE FOR THOSE SERVICES PROVIDED BY A PARTICIPATING DENTAL SOURCE GENERAL DENTIST. IF THE SERVICES OF A PARTICIPATING SPECIALIST ARE REQUIRED, MEMBERS WILL RECEIVE A DISCOUNT FROM THAT PARTICIPATING SPECIALIST.

PROCEDURES NOT LISTED ARE NOT COVERED BY DENTAL SOURCE.

Dental Source Dental Health Care Plans

Group Enrollment Form – M.N.E.A DHMO Plan

FAX: 1-281-313-7155

Part 1

1. GROUP NAME: Missouri National Education Association EFFECTIVE DATE:

2. SOCIAL SECURITY NUMBER	3. NAME (LAST) (FIRST)		
4. ADDRESS			
(CITY)	(STATE)	(ZIP CODE)	
5. WORK PHONE	6 HOME PHONE	7. DATE OF BIRTH (month/day/year)	8. SEX ○ Female ○ Male

9. DEPENDANT INFORMATION - LIST ALL ELIGIBLE DEPENDANTS YOU WISH COVERED.

Part 2

NAME LAST FIRST MI	DATE OF BIRTH	SEX	RELATION TO APPLICANT

Part 3

SELECTED DENTAL LOCATION NAME: **OFFICE LOCATION #**

Access the DHMO directory at www.densource.com or call 866-481-9473 to receive a copy by mail or fax

Part 4

Select a plan and coverage type.		Monthly Premium	
○ Member Only			
○ Member + 1			
○ Member + Family			

Part 5

I have read and understand the terms and conditions of the program and hereby request membership with Dental Source of Missouri & Kansas, Inc.

SIGNATURE	DATE

Date Received:		Date Approved		Approved By
Agent	Broker	SGA	Dist	Group

Dental Source of MO. & KS., Inc.

Select Any Dentist

Traditional (Passive) Dental Plan

Annual Benefit – Per Insured	**$1,000**
Calendar Year Deductible – Per insured (Max 3)	**$50**

TYPE I (PREVENTIVE SERVICES) — **100%**

Including:

- No waiting period
- Routine Exams
- Prophylaxis (cleanings-one per 6 months)
- Emergency exams for dental pain (minor procedures)
- Fluoride treatments for dependent children under age 19 (one per 12 months)
- Bitewing X-rays (once per 6 months)

TYPE II (BASIC SERVICES) — **80%**

Including:

- No waiting period
- Periapical X-rays
- Full mouth or panorex X-rays (one per 36 months)
- Simple restorative services (fillings)
- Simple extractions
- Palliative treatment for dental pain, local anesthesia
- Sealants for children ages 6-15 (one per tooth)

TYPE III (MAJOR SERVICES) — **50%**

Including:

- **12 month waiting period (Take over benefits may apply for current enrollees)**
- Major restorative services (crowns and inlays)
- Prosthetics (bridges, dentures)
- Replacement of prosthodontics, dentures, crowns and inlays
- Denture relines
- Endodontics/root canal therapy
- Periodontics
- Space maintainers
- Oral Surgery
- General anesthesia (for services dentally necessary)

ORTHODONTIC SERVICES

- Orthodontic care available for children & adults from the Dental Source Network of Orthodontic Specialists covered at 20%. No annual or lifetime maximum.

Out of Network covered at Usual, Customary, and Reasonable @ 90%

Takeover Benefits available for groups of 5 or more enrolled, as described under "Takeover Benefits"

Rate Guarantee 1 Year
DENTEMAX NETWORK
MISSOURI NATIONAL EDUCATIONAL ASSOCIATION

Marketed and Administered by: **DENTAL SOURCE OF MO & KS**
Underwritten By: **FIRST CONTINENTAL LIFE & ACCIDENT INSURANCE CO.**

Limitations and Exclusions

Covered Expenses Will Not Include and No Benefits Will be Payable:

1. For major services in the first 12 months that the Insured is covered, except as may be provided in the Takeover Benefits provision.
2. For any treatment which is for cosmetic purposes or to correct congenital malformations, except for medically necessary care and treatment of congenital cleft lip and palate.
3. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items, unless required because of an accidental bodily injury sustained while the Insured is covered. Replacement is not covered if the item can be repaired.
4. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of natural teeth during the same period of continuous coverage. But the extraction of a third molar (wisdom tooth) will not qualify the item for payment. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth. Coverage does not include the part of the cost that applies specifically to replacement of teeth extracted prior to the period of coverage.
5. For addition of teeth to an existing prosthetic appliance or fixed bridge unless for replacement of natural teeth extracted during the same period of continuous coverage.
6. For any expense incurred or procedure begun before the Insured's current period of continuous coverage.
7. For any expense incurred or procedure begun after the Insured's insurance under this section terminates, except for a prosthetic appliance, fixed bridge, crown, or inlay or onlay restoration for which both (a) the procedure begins before insurance ends and (b) the item's final placement is within 90 days after insurance ends.
8. To duplicate appliances or replace lost or stolen appliances.
9. For appliances, restorations or procedures to:
    a. alter vertical dimension;
    b. restore or maintain occlusion;
    c. splint or replace tooth structure lost as a result of abrasion or attrition; or
    d. treat jaw fractures or disturbances of the Temporomandibular joint.
10. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
11. For broken appointments or the completion of claim forms.
12. For orthodontia service or for any services associated with orthodontic therapy when this optional coverage is not elected and the premium is not paid.
13. For sealants which are:
    a. not applied to a permanent molar;
    b. applied before age 6 or after attaining age 16; or
    c. reapplied to a molar within three years from the date of a previous sealant application.
14. For subgingival curettage or root planing (procedure numbers 4220 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
15. Because of an Insured's injury arising out of, or in the course of, work for wage or profit.
16. For an Insured's sickness, injury or condition for which he or she is eligible for benefits under any Workers Compensation Act or similar laws.
17. For charges for which the Insured is not liable or which would not have been made had no insurance been in force.
18. For services which are not recommended by a dentist, not required for necessary care and treatment, or do not have a reasonably favorable prognosis.
19. Because of war or any act of war, declared or not, or while on full-time active duty in the armed forces of any country.
20. To an Insured if payment is not legal where the Insured is living when expenses are incurred.
21. For any services related to: equilibration, bite registration or bite analysis.
22. For crowns for the purpose of periodontal splinting.
23. For charges for: any implants; overdentures; precision or semi-precision attachments and associated endodontic treatment; other customized attachments; or specialized prosthodontic techniques or characterizations.
24. For charges for myofunctional therapy, orthognathic surgery or athletic mouthguards.
25. For procedures for which benefits are payable under the employer's medical expense benefits plan for employees and their dependents.
26. Services or supplies provided by a family member or a member of the Insured's household.

Note: This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. See your certificate for details.

Predetermination of Benefits: As a service to protect the Insured, First Continental Life & Accident Insurance Co. will provide predetermination of benefits for recommended treatment plans that exceed $300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. This benefit helps Insured's better understand their coverage. The Insured should submit the treatment plan to First Continental Life & Accident Insurance Co. for review and predetermination of benefits before the service begins.

TAKEOVER BENEFITS

Takeover means that you are given credit for waiting periods for like coverage's accumulated under your existing plan. No credit is given for deductibles satisfied under your existing plan.

1. In order to provide Takeover Benefits your employer's current dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan.
2. All employees insured on the effective date with continuous coverage from the prior group dental contract are eligible for Takeover Benefits. Waiting periods will be reduced by the amount of time insured under the prior plan.
3. A minimum of five (5) enrolled members are needed for an employer to be eligible for Takeover Benefits.
4. Takeover Benefits must be requested and are subject to the approval of First Continental Life & Accident Insurance Co.

Submission of Claims:
First Continental Life & Accident Insurance Co.
ATTN: Claims Department
12946 Dairy Ashford, Suite 360
Sugar Land, TX. 77478

Verification of Claims:
281-313-7170 (local)
1-866-481-9473 (toll free)

DentalSource

100/80/50 Plan

GROUP DENTAL ENROLLMENT FORM

First Continental life & Accident Insurance Company
12946 Dairy Ashford Suite 360 Sugar Land, TX 77478
Phone (866) 481-9473 Fax (281) 313-7155

To Be Completed By Group

Name of Group (Use Name from Group Billing Notice or Master Application)	Group Number	DIV	CLASS
Missouri National Education Association	K306655		

To Be Completed By All Members

Social Security Number	**Effective Date** Month / Day / Year	**Date Employed Fulltime** Month / Day / Year	**Hours Worked per Week**
	/ /	/ /	

Your Name (Last), (First), (Middle Initial)	**Date of Birth** Month / Day / Year	**Sex** Male ☐ Female ☐
	/ /	

Home Address:

_____

_____

_____

Do you have any other Dental coverage? If so, Carrier_____

Coverage Requested

☐ Member Only

☐ Member + 1

☐ Member + Family

(Complete for Dependent Coverage)

	Spouse Name (Last), (First), (Middle Initial)	**Date of Birth**	**Do any of your dependents have any other dental coverage?**	**If so, Name of Carrier**
		/ /	☐ Yes ☐ No	
CHILDREN	1	/ /	☐ Yes ☐ No	
	2	/ /	☐ Yes ☐ No	
	3	/ /	☐ Yes ☐ No	
	4	/ /	☐ Yes ☐ No	
	5	/ /	☐ Yes ☐ No	

Fraud Warning (Not Applicable in AZ, FL, MD, or VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

Fraud Warning (FL only): 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 of the third degree.

I elect the dental coverage selected for which I am eligible. .

Date_____ **Member Signature:** _____

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date_____ **Member Signature:** _____

Vision Plan Highlights

Plan covers the entire family.

DENTAL SOURCE'S PROGRAM

Dental Source offers the US VISION PLAN, a Discount Preferred Provider Network (DPPN). Unlike vision insurance our plan has no waiting periods, no limitations or exclusions, no annual/lifetime maximums, and no claim forms. Simply visit a USVISIONPLAN.COM Provider, show your member card, and pay the adjusted bill.

USVISIONPLAN.COM's vision benefit programs embrace the UNA commitment to 100% customer satisfaction. Our program includes a laser vision correction program using a national network of surgeons. Qualified candidates receive hundreds of dollars off each network surgeon's lowest advertised price. The discount program includes the initial prescreening, post-operative care and reimbursement for initial prescription on post-operative drops.

Over 3 million people receive vision benefits through USVISIONPLAN.COM's vision care program. The key to our success has always been our focus on forming mutually beneficial, long-term relationships with all of our plan sponsors and our commitment to the satisfaction of our plan members! USVISIONPLAN.COM is your simple solution to vision benefits!

$25 Eyeglasses "New"

Eye Exams	5% to 20% Discount
Frames	20% to 50% off retail
Lenses	20% to 25% off retail
LASIK	15% to 55% discount
CRT procedure	20% to 25% discount
Online Contact Lenses	Best Price Guarantee

Note: Fees vary by vendor and vendor location. The deepest discounts can be found at Target Optical, JC Penny Optical, Pearle Vision Centers, and Sears Optical.

Cards can be printed from www.densource.com or just call 866-481-9473 and a customer service representative will send you one.