

**Security Life Insurance Company of America, Minnetonka, MN  
PRIMESTAR PERSONAL APPLICATION - 3 ENROLLMENT OPTIONS**

**ONLINE** - Visit [www.StarsDental.com/quote](http://www.StarsDental.com/quote)  
and follow the step by step Instructions  
Agent Authorization Number (Required for  
Online purchases) (AAN) \_\_\_\_\_

**FAX** - the application to 206-521-9554  
(You must choose Credit Card or  
ACH payment options)

**Mail** - the application along with initial payment to:  
**Matrix Insurance Marketing, Inc.**  
1225 So.Weller St.Suite320  
Seattle,WA98144- 1906

**Plan Selection:**  Elite  Premier  Select  Vision Option  Senior (65 or older)  
**Optional Calendar Year Maximum Increase Selection**  \$1,500  \$2,000

**I apply for coverage on:**  Applicant Only  Applicant and Spouse  
 Applicant and Child(ren)  Applicant and Family

APPLICANT INFORMATION (PLEASE PRINT CLEARLY)					
Last Name		First Name		Initial	
Address			Telephone Number		Birth Date: / /
City			State	Zip	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Billing Address (if Different)		City		State	Zip
Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/>					

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW					
Last Name (if Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

Does Spouse have a dental plan: Yes  No  With Whom? \_\_\_\_\_ If answer is "Yes", are dependents enrolled under spouses plan? Yes  No

Do you claim a tax exemption for all eligible dependents listed above? Yes  No  If no, who is not? \_\_\_\_\_

All dependent children over age 18 are full-time students. Yes  No  If no, who is not? \_\_\_\_\_

CALCULATE YOUR RATES:	
1. Locate the first three digits of your zip code on the <b>Zip Code Area Chart</b> found on the reverse side of this application. Using the corresponding area number, determine the applicable monthly premium, found on the <b>Rate Chart</b> on the reverse side of this application, based upon your eligibility age, plan selection and coverage type.	
2. Select your mode of payment	
<input type="checkbox"/> <b>Monthly - Bank Account Debit (ACH)</b> (Checking or Savings) Complete Authorization Agreement below and submit two (2) months premium	
<b>Checking Acct.</b> - Attach voided check - DO NOT SUBMIT DEPOSIT SLIP.	
<b>Savings Acct.</b> - Attach savings deposit slip with account number including the bank routing number.	
<input type="checkbox"/> <b>Monthly Credit Card</b>	
Complete Authorization Agreement below.	
<input type="checkbox"/> Visa <input type="checkbox"/> Master Card	<input type="checkbox"/> <b>Quarterly Direct Bill</b> - submit three (3) months premium
	<input type="checkbox"/> <b>Semi-Annual Bill</b> - submit six (6) months premium
Card # _____	Expiration Date ____/____/____

**Authorization To Convert Your Check To An Electronic Funds Transfer Debit** - By sending your check to us, you authorize **Security Life Insurance Company of America** to convert the check into an electronic funds transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment.

Monthly Rate (found on the Premium Rate Table)	Vision Add-on (found on the Premium Rate Table)	Optional Calendar Yr Max Add-on \$1,500 Additional Cost \$6.00 \$2,000 Additional Cost \$9.00	Sub Total:	Multiply by 2,3 or 6 depending upon mode of payment selected above	One time enrollment Fee	Total Remittance
\$	\$	\$	\$	X	None	\$

**For Initial payment, make check payable to Security Life Insurance Company of America**

AUTHORIZATION AGREEMENT: (When paying by ACH or Credit Card please complete the section below)	
As a convenience to me, I authorize Security Life Insurance Company of America to initiate entries to my bank account or credit card account for my monthly dental and/or vision premium. I understand this will occur by the third business day of each month and that such record will appear on my monthly statement. I agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, the bank or credit card company shall be under no liability whatsoever even though it might result in forfeiture of my insurance.	
I understand that this agreement will remain in effect until Security Life Insurance Company of America has received written notice from me that it should be cancelled. I understand that I have the right to stop payment by notification to Security Life Insurance Company of America, my bank or my credit card company at least ten business days prior to the next scheduled payment.	
Account Holder's Name _____	Date _____ Account Holder's Signature _____

FOR AGENT USE ONLY - Please Print Clearly				FOR COMPANY USE ONLY	
Producer Name		Producer Phone #		Effective Date: ____/____/____	
Street Address		City	St	Zip	Plan Code: _____ SLIC
Producer Email		Producer SS#/TIN#			
Appointed with Security Life? <input type="checkbox"/> Yes <input type="checkbox"/> No		Producer Signature			

**IMPORTANT INFORMATION** - The effective date is the first of the month following the day in which the application is received in the Service Center Office. Upon receipt of your completed application you will receive a copy of your Certificate of Insurance and Identification Card(s). Do not cancel any other dental coverage you may have until you receive written confirmation from Security Life. Please allow 3-4 weeks for processing.

**By my signature below, I hereby apply for coverage under Group Dental Insurance Policy GH-1112-38060-02 issued to the Voluntary Group Trust. I also certify I have read the applicable Fraud Notice contained within the brochure.**

**California Law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_