Air Force Sergeants Association

GROUP DENTAL INSURANCE PLAN ENROLLMENT FORM

The United States Life Insurance Company in the City of New York

TO ENROLL:

Send this completed form with your Premium check payable to
ADMINISTRATOR
AFSA
GROUP INSURANCE PROGRAM
P.O. BOX 10374
Des Moines, IA 50306-0374

QUESTIONS?
Call: 1-800-882-5541
www.personal-plans.com/afsa

PLEASE PRINT IN INK OR TYPE - DO NOT USE CORRECTION FLUID OR GEL PEN - INITIAL AND DATE ANY CHANGES

ENROLLEE— Please print or type. Complete all areas, sign and date.

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Social Security # _____

Date of Birth _____ Sex ❑ M ❑ F
(Mo./Day/Yr.)

Phone Numbers

(_____) _____
Home

(_____) _____
Work

E-Mail _____
Marsh will not share your email information.

Eligibility Date _____
(FOR OFFICE USE ONLY)

MEMBERSHIP AFFILIATION

I am a member of the Air Force Sergeants Association

❑ Yes ❑ No Membership # _____

Membership in AFSA is required for participation in the plan.

SPOUSE INFORMATION— Complete only if spouse is to be covered.

Spouse Name _____ Date of Birth _____
(first, middle, last name only if different) (Mo./Day/Yr.)

Spouse's Social Security # _____ Sex ❑ M ❑ F

DEPENDENT CHILD(REN) INFORMATION— Complete only if dependent child(ren) is (are) to be covered. If you desire coverage for more than two children, please attach a separate sheet including the information below.

Name of Child _____ Date of Birth _____
(first, middle, last name only if different) (Mo./Day/Yr.)

Child's Social Security # _____ Sex ❑ M ❑ F

Name of Child _____ Date of Birth _____
(first, middle, last name only if different) (Mo./Day/Yr.)

Child's Social Security # _____ Sex ❑ M ❑ F

BE SURE TO COMPLETE AND SIGN REVERSE SIDE

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RATE AND BILLING OPTIONS

Please select the type of coverage you would like. Enclose a check for the rate selected and mail it with this Enrollment Form to Marsh Affinity Group Services. Even if you select Automatic Check Withdrawal, you are required to send a check for your first month's premium along with a blank voided check.

❑ Member Only

❑ Family

❑ Member +1

Indicate how you wish to be billed:

❑ **Automatic Monthly Check Withdrawal**

❑ **Quarterly Direct Bill**

(If you select Automatic Monthly Check Withdrawal, please complete the Automatic Monthly Check Withdrawal request on the next page.)

Only dependent children under age 19 are eligible for orthodontic coverage.

PLEASE READ AND SIGN

I have read and understand the conditions and exclusions of the program. I hereby enroll in The Group Dental Insurance Plan for Air Force Sergeants Association Members. I understand that the insurance enrolled for shall become effective on the date specified by The United States Life Insurance Company in the City of New York only if this Enrollment Form is accepted and the first premium is paid by the Effective Date. I represent that to the best of my knowledge and belief all statements and answers recorded above are true and complete.

Important Notice — Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. (Fraud provisions vary by state.)

✗ _____ ✗ _____

Member's Signature Date

AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below. ***Remember to include your first premium and a blank voided check with your application.***

Bank Name: _____

Bank Address: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer _____ **Date** _____

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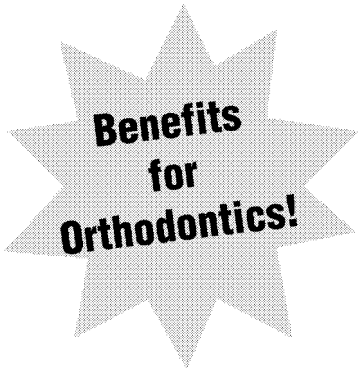
Group Dental Insurance Plan

FOR AIR FORCE SERGEANTS ASSOCIATION MEMBERS AND THEIR FAMILIES

VALUABLE INSURANCE PROTECTION FOR YOUR DENTAL HEALTH



Caring for your teeth should be part of a sound health care program. Yet such basic care can cost hundreds—if not thousands—of dollars annually. Consider this: More than 130 million Americans do not have dental insurance.*

So, where can you find the extra money to cover your dental expenses? Avoiding the dentist is not a solution. Ignoring care today can prove to be even more costly down the road—both to your teeth AND to your bank account. Fortunately, you can now enjoy important dental protection designed specifically to meet the needs of you and your family with this economical group dental insurance plan.

The AFSA Dental Plan is dental insurance, not a discount plan. Insurance helps protect you when you need it most. It pays for your preventive care as well as for emergency care or specialty dental treatment.

Here's Why The AFSA Dental Insurance Plan Is Important To You Now:

- "Tooth decay affects more than one-fourth of U.S. children aged 2-5 and half of those aged 12-15." "One fourth of adults over age 60 have lost all of their teeth--primarily because of tooth decay, which affects more than 90% of adults over age 40, and advanced gum disease, which affects 5-15% of adults". "An estimated 31,000 people will learn they have mouth or throat cancer, and more than 7,400 will die of these diseases."*
- "Many children and adults still go without measures that have been proven effective in preventing oral diseases and reducing dental care costs."*
- "In 2006, Americans made about 500 million visits to dentists, and an estimated $94 billion was spent on dental services."*

***According to the Center for Disease Control and Prevention publication *Oral Health: Preventing Cavitities, Gum Disease, and Tooth Loss - At a Glance, 2008.* www.cdc.gov/NCCDPHP/publications/aag/oh.htm. Viewed 9/5/08**

Here's How The Plan Works

The plan provides benefits for diagnostic and preventive care as well as most forms of specialty dental treatment. You may go to any dentist you wish. The Schedule of Dental Services identifies the maximum allowable benefit you and your dependents receive when a procedure is performed. The dollar amount assigned to each procedure is the maximum you receive, not to exceed actual charges. Under the AFSA Dental Insurance Plan, you can request that the benefits be paid either directly to the dentist or you can be reimbursed for the benefit.

Eligibility

You and your eligible dependents may enroll for coverage. Eligible dependents include a lawful spouse and dependent children, typically under age 21 (age 25 if a full-time student). (Subject to state variations.)

PLAN FEATURES

- You select your own dentist—guaranteed. Benefits are provided for 155 different dental services.
- No waiting period for preventive, diagnostic, restorative or adjunctive services.
- Choose to have the benefits paid to you or directly to the dentist.
- Your acceptance into this plan is not subject to underwriting approval.

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Annual Maximums

You and your covered dependents are entitled to receive up to $1,000 each in dental benefits per calendar year after the cash deductible is satisfied. A lifetime maximum benefit of $850 applies to orthodontic benefits for insured dependent children under age 19.

Deductibles

For all services, a deductible of $50 per insured person, per calendar year is required, up to $150 maximum per family unit. The deductible is applied against insurance-covered expenses, not billed charges.

Waiting Period

Preventive, Diagnostic, Restorative and Adjunctive Services are provided immediately. Endodontics and Oral Surgery have a 6-month waiting period. All other benefits have a 12-month waiting period. Once you have been enrolled under the plan for 12 consecutive months, you are eligible for benefits under Restorative-Major, Periodontics, Prosthetics-Removable, and Fixed Bridge. For orthodontics coverage for insured dependent children under age 19, there is a 12-month waiting period.

ECONOMICAL PLAN COST

The AFSA Dental Insurance Plan offers a plan with orthodontics benefits for insured dependent children under age 19. Please refer to the rates below for the economical plan cost.

Member Only	$29.33 Monthly or $88.00 Quarterly
Member +1	$45.33 Monthly or $136.00 Quarterly
Family	$61.67 Monthly or $185.00 Quarterly

PAYMENT OPTIONS

You are able to choose between two premium payment options, whichever one best suits your needs.

Option 1:

Pay through Automatic Monthly Check Withdrawal. This saves you the time spent writing checks and remembering due dates.

Option 2:

Pay through direct billing on a quarterly basis.

All billing modes except annual will include a $2.00 billing fee. To avoid the fee, select Automatic Monthly Check Withdrawal as a safe and secure payment option.

OTHER IMPORTANT INFORMATION

When Coverage Terminates

Your dental coverage will be terminated only if you cease to be a member of your association; you fail to pay the appropriate premium when due; or the group policy is discontinued. Coverage for your dependents will be terminated if your insurance ends, dependents' insurance ends under the group policy, the person ceases to be a dependent or premium is not paid for the dependent when due.

Effective Date

Your coverage will be effective the first day of the month following receipt of your Enrollment Form and first premium. Some services are subject to a 6 to 12-month waiting period; see "Waiting Period" section above.

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Exclusions

No benefits will be paid for expenses incurred:

1. For any portion of a charge for any service in excess of the scheduled benefit shown in the Schedule of Dental Services.
2. For any procedure not listed as a scheduled benefit in the Schedule of Dental Services.
3. For overdentures and associated procedures.
4. For cosmetic procedures, including charges for porcelain or other veneer crowns, pontics, and porcelain or other veneer facings on crowns or pontics to replace molars.
5. For the replacement of full and partial dentures, bridges, inlays, on-lays or crowns that can be repaired or restored to normal function.
6. For implants; and for (a) the replacement of lost or stolen appliances; (b) the replacement of orthodontic retainers; (c) athletic mouthguards; (d) precision or semi-precision attachments; (e) denture duplication or for (f) sealants, except as specifically provided in the Schedule of Dental Services.
7. For oral hygiene instructions; and for (a) plaque control; (b) the completion of a claim form; (c) acid etch; (d) broken appointments; (e) prescription or take-home fluoride; or for (f) diagnostic photographs.
8. For services and procedures that are begun, but not completed by the end of the month in which coverage terminates.
9. For charges in connection with an orthodontic service or procedures, except to the extent specifically provided by the group policy.
10. For charges incurred for treatment which would be given free of charge if you were not insured.
11. For charges incurred for treatment which results from a war or an act of war.
12. For care or treatment of a condition for which you are entitled to or eligible for benefits under any Worker's Compensation Act or similar law.
13. For charges that are applied toward satisfaction of a Deductible, if any.
14. For services that are not recommended, approved and certified as necessary and reasonable by a dentist.
15. For services that are not approved by the Council of Dental Therapeutics of the American Dental Association.
16. For charges incurred for treatment which results from intentionally self-inflicted injury.
17. For charges incurred for treatment which is given by a person's spouse or his or his spouse's father, mother, son, daughter, brother, or sister.
18. For charges incurred for treatment which is given by a person's employer or an employee of such employer.
19. For charges that are given after a person's insurance ends, regardless of when the injury or sickness occurred.
20. For charges that are not essential for the necessary care or treatment of the injury or sickness involved.

All persons who were previously insured for dental insurance under this plan and later voluntarily end insurance will not be eligible to re-enroll for a period of two years following the date insurance was voluntarily ended.

Certificate Of Insurance

When you become insured, you will be sent a Certificate of Insurance summarizing the provisions of the plan under which you are insured.

Payment And Claims

Under the AFSA Dental Insurance Plan, you can request the benefits be paid either directly to your dentist, or you can be reimbursed for the benefit. Once you are accepted into the plan, you will have a 31-day grace period for your payment of renewal premiums.

30-Day Free Look

When you become an insured, you will be sent a Certificate of Insurance summarizing your insurance coverage. If you are not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days and your premium will be promptly refunded. Your coverage will then be invalidated.

How to Enroll

It's easy to enroll in the AFSA Dental Insurance Plan. Simply fill out the enclosed form and be sure to indicate your billing preference. If you are paying through automatic monthly check withdrawal, you must also include a check for your first month's premium and a blank voided check or a deposit slip. If you are paying through quarterly direct bill, just include a check for your first quarterly premium. Make checks payable and mail to:

Administrator
AFSA Group Insurance Program
P.O. Box 10374
Des Moines, IA 50306-0374

Questions? We're only a phone call away!

We want to provide you with the best possible service. For more information about this plan or if you have any specific questions, just call us toll-free at: 1-800-882-5541.

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Please Note: This Is Only An Outline.

This brochure is a brief summary of benefits only and is subject to the terms, conditions, limitations and exclusions of Group Policy No. G-227,633, Form No. G-19000. Coverage may vary or may not be available in all states. It is, therefore important you READ CERTIFICATE CAREFULLY.

The Group Dental Insurance Plan is Underwritten By:

The United States Life Insurance Company in the City of New York

3600 Route 66
P.O. Box 1580
Neptune, NJ 07754-1580

The most prominent independent ratings agencies continue to recognize The United States Life Insurance Company in the City of New York in terms of insurer financial strength. For current insurer financial strength ratings, please consult the Web site at www.americangeneral.com/ratings.

The underwriting risks, financial and contractual obligations and support functions associated with the products issued by The United States Life Insurance Company in the City of New York (United States Life) are its responsibility.

The Group Dental Insurance Plan is Administered By:

MARSH

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

P.O. Box 10374
Des Moines, IA 50306-0374

Questions?
1-800-882-5541
www.personal-plans.com/afsa

AR Ins. Lic. #245544
CA License #0633005
d/b/a in CA Seabury & Smith Insurance Program Management

Rates will not be changed unless they are changed for all insureds within your classification.

Group Policy G-227,633 DE385P

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Schedule of Dental Services
The AFSA Group Dental Insurance Plan

ADA Code		$ Insurance Allowance
I. Preventive		
0120	Periodic oral evaluation, six (6) month interval	$15
0140	Limited oral evaluation – problem focused	25
0150	Comprehensive oral evaluation	25
1110	Prophylaxis – adult, once in a six (6) month interval	40
1120	Prophylaxis – child, once in a six (6) month interval	25
1203	Topical application of fluoride (prophylaxis not included) – at twelve (12) month intervals to age 19	15
1351	Sealants, per tooth – 1st and 2nd molars within two years of eruption	10
9110	Palliative (emergency) treatment of dental pain – minor procedure	15
II. Diagnostic		
0210	Intraoral – complete series (including bitewing-thirty-six (36) month interval)	$45
0220	Intraoral – periapical – first film	10
0230	Intraoral – periapical – each additional film	5
0240	Intraoral – occlusal film	10
0270	Bitewing – single film – six (6) month interval	15
0272	Bitewings – two films – six (6) month interval	15
0274	Bitewings – four films – six (6) month interval	20
0330	Panoramic film	35
0340	Cephalometric film	50
III. Restorative		
1520	Space maintainer – removable – unilateral	$25
1525	Space maintainer – removable – bilateral	50
2140	Amalgam – one surface, permanent	30
2150	Amalgam – two surfaces, permanent	35
2160	Amalgam – three surfaces, permanent	35
2161	Amalgam – four or more surfaces, permanent	35
2330	Resin – one surface, anterior	30
2331	Resin – two surfaces, anterior	35
2332	Resin – three surfaces, permanent	45
2335	Resin – four or more surfaces or involving incisal angle (anterior)	50

ADA Code		$ Insurance Allowance
IV. Restorative – Major		
2520	Inlay – metallic – two surfaces	$145
2530	Inlay – metallic – three or more surfaces	150
2543	Onlay – metallic – three surfaces	155
2544	Onlay – metallic – four or more surfaces	155
2620	Inlay – porcelain/ceramic – two surfaces	145
2630	Inlay – porcelain/ceramic – three or more surfaces	145
2643	Onlay – porcelain/ceramic – three surfaces	145
2644	Onlay – porcelain/ceramic – four or more surfaces	145
2710	Crown – resin (laboratory)	100
2720	Crown – resin with high noble metal	200
2721	Crown – resin with predominantly base metal	180
2722	Crown – resin with noble metal	210
2740	Crown – porcelain/ceramic substrate	215
2750	Crown – porcelain fused to high noble metal	230
2751	Crown – porcelain fused to predominantly base metal	220
2752	Crown – porcelain fused to noble metal	220
2780	Crown – 3/4 cast metal	220
2790	Crown – full cast high noble metal	225
2791	Crown – full cast predominantly base metal	215
2792	Crown – full cast noble metal	215
2910	Recement inlay	15
2920	Recement crown	15
2930	Prefabricated stainless steel crown – primary tooth	50
2950	Core buildup, including any pins	45
2951	Pin retention – per tooth, in addition to restoration	10
2952	Cast post and core in addition to crown	68

ADA Code		$ Insurance Allowance

V. Endodontics

3220	Therapeutic pulpotomy (excluding final restoration)	$20
3310	Root Canal – Anterior (excluding final restoration)	125
3320	Root Canal – Bicuspid (excluding final restoration)	135
3330	Root Canal – Molar (excluding final restoration)	140
3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforation, root resorption, etc.)	70
3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations,root resorption, etc.)	40
3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorptions, etc.)	30
3410	Apicoectomy/Periradicular surgery – anterior	115
3450	Root Amputation – per root	35
3920	Hemisection (including any root removal), not including root canal therapy	80
3950	Canal preparation and fitting of preformed dowel or post	25

VI. Periodontics

4210	Gingivectomy or gingivoplasty – per quadrant	$75
4211	Gingivectomy or gingivoplasty – per tooth	45
4240	Gingival flap procedure, including root planing – per quadrant	110
4249	Clinical crown lengthening – hard tissue	20
4260	Osseous surgery (including flap entry and closure) – per quadrant	205
4263	Bone replacement graft – first site in quadrant	20
4270	Pedicle soft tissue graft procedure	110
4271	Free soft tissue graft procedure (including donor site surgery)	110
4341	Periodontal scaling and root planing – per quadrant	30
4910	Periodontal maintenance procedures (following active therapy) – once in a six (6) month interval	35

ADA Code		$ Insurance Allowance

VII. Prosthetics – Removable

5110	Complete denture – maxillary	$250
5120	Complete denture – mandibular	250
5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	110
5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	110
5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	130
5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	130
5410	Adjust complete denture – maxillary	15
5411	Adjust complete denture – mandibular	15
5421	Adjust partial denture – maxillary	15
5422	Adjust partial denture – mandibular	15
5510	Repair broken complete denture base	20
5520	Replace missing or broken teeth – complete denture (each tooth)	20
5610	Repair resin denture base	20
5620	Repair cast framework	30
5630	Repair or replace broken clasp	15
5640	Replace broken teeth – per tooth	20
5650	Add tooth to existing partial denture	40
5660	Add clasp to existing partial denture	40
5710	Rebase complete maxillary denture	45
5711	Rebase complete mandibular denture	45
5720	Rebase maxillary partial denture	45
5721	Rebase mandibular partial denture	45
5730	Reline complete maxillary denture (chairside)	55
5731	Reline complete mandibular denture (chairside)	55
5740	Reline maxillary partial denture (chairside)	55
5741	Reline mandibular partial denture (chairside)	55
5750	Reline complete maxillary denture (laboratory)	75
5751	Reline complete mandibular denture (laboratory)	75
5760	Reline maxillary partial denture (laboratory)	75
5761	Reline mandibular partial denture (laboratory)	75
5850	Tissue conditioning maxillary	25

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ADA Code		$ Insurance Allowance

VIII. Fixed Bridge

1510	Space maintainer – fixed – unilateral	$90
1515	Space maintainer – fixed – bilateral	115
6210	Pontic – cast high noble metal	165
6211	Pontic – cast predominantly base metal	185
6212	Pontic – cast noble metal	185
6240	Pontic – porcelain fused to high noble metal	200
6241	Pontic – porcelain fused to predominantly base metal	200
6242	Pontic – porcelain fused to noble metal	200
6250	Pontic – resin with high noble metal	200
6251	Pontic – resin with predominantly base metal	150
6252	Pontic – resin with noble metal	150
6545	Retainer – cast metal for resin bonded fixed prosthesis	150
6720	Crown – resin with high noble metal	170
6721	Crown – resin with predominantly base metal	165
6722	Crown – resin with noble metal	165
6750	Crown – porcelain fused to high noble metal	180
6751	Crown – porcelain fused to predominantly base metal	165
6752	Crown – porcelain fused to noble metal	165
6780	Crown – 3/4 cast high noble metal	170
6790	Crown – full cast high noble metal	175
6791	Crown – full cast predominantly base metal	175
6792	Crown – full cast noble metal	165
6930	Recement fixed partial denture	25

IX. Oral Surgery

7140	Single tooth	$20
7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	30
7220	Removal of impacted tooth – soft tissue	45
7230	Removal of impacted tooth – partially bony	70
7240	Removal of impacted tooth – completely bony	85
7241	Removal of impacted tooth – completely bony, with unusual surgical complications	85
7250	Surgical removal of residual tooth roots (cutting procedure)	30
7285	Biopsy of oral tissue – hard	25
7286	Biopsy of oral tissue – soft	25

ADA Code		$ Insurance Allowance

IX. Oral Surgery (continued)

7320	Alveoloplasty in conjunction with extractions – per quadrant	75
7410	Excision of benign tumor – lesion diameter up to 1.25 cm	65
7411	Excision of benign tumor – lesion diameter greater than 1.25 cm	65
7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	65
7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	65
7450	Removal of odontogenic cyst or tumor – lesion diameter up to 1.25 cm	70
7451	Removal of odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	70
7460	Removal of nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	70
7461	Removal of nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	70
7465	Destruction of lesion(s) by physical or chemical method, by report	70
7471	Removal of exostosis – maxilla or mandible	100
7510	Incision and drainage of abscess – intraoral soft tissue	35
7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	60
7970	Excision of pericoronal gingival	75

X. Adjunctive Services

9220	General anesthesia – first 30 minutes	$50
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	20

XI. Orthodontics

The lesser of 50% of the dentist's fee or 50% of the reasonable and customary charge not to exceed the overall maximum dental benfit. Orthodontics applies only to insured children under age 19.

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AG-7185T 7/09

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