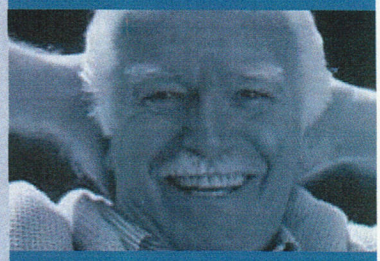
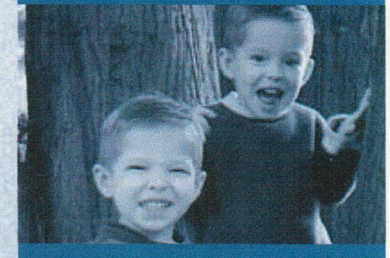
A Dental Insurance Plan For You & Your Family





SPIRIT DENTAL®

INDEMNITY AND DHA-PREMIER PPO

No Waiting Periods

Choose Your Own Dentist

Three Cleanings Per Year

Covers Major Dental Services

Optional Vision Coverage

Fully Insured by Security Life Insurance Company of America

Distributed by: DIRECT BENEFITS INC.

Plan Coordinator:

Direct Benefits, Inc.
325 Cedar Street, Suite 800
Saint Paul, MN 55101
651.649.3503 • 800.620.5010
www.directbenefits.com
www.spiritdental.com

Policy GH-1112-37740-1
Form S11096 (Rev 4-10)

SPIRIT DENTAL®

Indemnity – Choose Your Own Dentist

This Dental Insurance Plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions, as well as crowns, bridges and dentures..

This policy reimburses you for covered dental expenses based upon a percentage of the Reasonable and Customary (R&C) fees for those covered expenses after the $50 lifetime deductible has been satisfied on Preventive Services and the $50 combined calendar year deductible has been satisfied on Basic and Major Services. These percentages are: 100% for PreventiveServices, 70% for Basic and 10% for Major Services in the 1st year. In the 2nd year of coverage, Basic Services increase to 80% and 50% for Major. In the 3rd year, Basic Services increase to 90%.

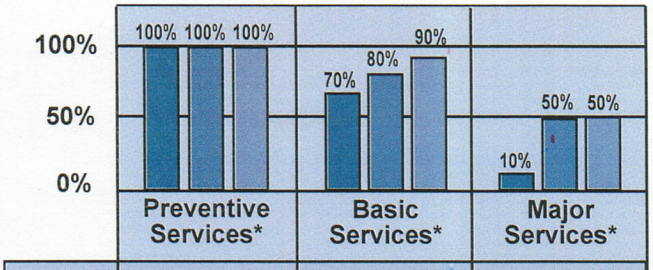
Spirit Dental allows you to select your own dentist, and it is affordable for you and your family.

* $50 Preventive Lifetime deductible per person to a maximum of 3 Individual deductibles per family
* $50 combined Basic/Major Annual deductible per person to a maximum of 3 Individual deductibles per family
* $1200 calendar year maximum benefit per person
* $2000 calendar year maximum option for 10% rate increase

REASONABLE AND CUSTOMARY - means the usual, customary and regular charges for the area where such expenses are incurred.

NOTICE: This brochure provides a very brief description of some important features of your Plan. It is not the Insurance Contract, nor does it represent the Insurance Contract. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Policy Form GH-1112-37740-1 issued to the Voluntary Group Trust.

Covered Services



	Preventive Services*	Basic Services*	Major Services*
Year 1	100%	70%	10%
Year 2	100%	80%	50%
Year 3	100%	90%	50%

PREVENTIVE^
-- two exams per year
-- three cleanings per year

BASIC *
-- Space maintainers
-- one series of bitewing x-rays per year
-- Sealants (children to age 16)
-- one topical flouride per year to age 16

MAJOR *
-- Simple extractions
-- Implants (endosteal only), up to the allowance for the lowest cost covered traditional procedure
-- One diagnostic x-ray, full or panoramic in any 3 year period
-- Oral surgery
-- Endodontic treatment
-- Periodontic services
-- Restoration services; inlays, onlays and crowns
-- Prosthetic services; bridges and dentures
-- Basic fillings

PLAN INFORMATION

ELIGIBLE EXPENSES: Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To become an Eligible Expense, the dental services must be performed by: a licensed Physician performing dental services within the scope of his license; or a licensed dental hygienist acting under the supervision and direction of a Dentist.

EXPENSES INCURRED: An Eligible Expense is considered incurred on the following dates: for full and partial dentures - on the date the final impression is taken; for fixed bridges, crowns, inlays and onlays - on the date the teeth are first prepared; for root canal therapy - on the date the pulp chamber is opened; for peridontal surgery - on the date surgery is performed; for all other services - on the date the service is performed.

DENTAL EXPENSES NOT COVERED: No benefits will be paid for expenses incurred: for overdentures and associated procedures for charges in excess of those considered reasonable and customary; for cosmetic procedures; for the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function; for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication; for oral hygiene instructions and for plaque control, completion of a claim form, acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs; for services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us; for procedures that are begun, but not completed; for services and treatment provided without charge or for which there would be no charge in the absence of insurance; for services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries; for a condition covered under any Worker's Compensation Act or similar law; that are applied toward satisfaction of a Deductible, if any; that are generally considered by the dental profession as experimental or investigational; for the treatment of cleft palate and anodontia; for services or supplies payable under any medical expense plan; for orthodontia, unless included within Coverage Schedule; prior to the date the Insured is covered under the Policy; for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD); for hospital services; for any unmarried child age 19 years of age and over unless he is dependent upon You for support, while a full-time student. A full-time student is one who is enrolled for 12 semester hours for credit in an accredited junior college, college or university. Any exception for a full-time student will end at age 23; if You voluntarily end your insurance You will not be eligible to re-enroll for a period of 2 years after the date Your coverage first ended; charges for infection control, sterilization and waste disposal.

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

MISSING TOOTH: When covered under your plan, benefits are provided for placement of dentures, fixed bridgework, implants or the addition of teeth to existing dentures only when the service includes replacement of a natural tooth extracted or lost while covered under this plan. This limitation ends after the individual receiving care has been covered under this plan for 36 consecutive months.

GENERAL INFORMATION

ELIGIBILITY: Individuals 18 and over plus their eligible dependents (spouse and unmarried children from birth to age 19; extended to age 23 if child is a full-time student). This is subject to state requirements.

DEDUCTIBLE AMOUNT: The Deductible is shown in the Coverage Schedule. The Deductible is an amount of covered dental charges incurred by an insured person for which no benefits will be paid.

CALENDAR YEAR MAXIMUM: The maximum amount payable for all Eligible Dental Expenses in any calendar year as shown in the Coverage Schedule. The Calendar Year Maximum will apply to each insured person.

PRETREATMENT REVIEW: If the Course of Treatment will exceed $300, We will request prior review. We must be given the dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate, less expensive Course of Treatment if it will produce professionally satisfactory results. If You do not request a pretreatment review, We will pay for the least expensive method of treatment regardless of the method actually used.

COORDINATION OF BENEFITS: This Plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits. This helps keep the cost of the Plan reasonable.

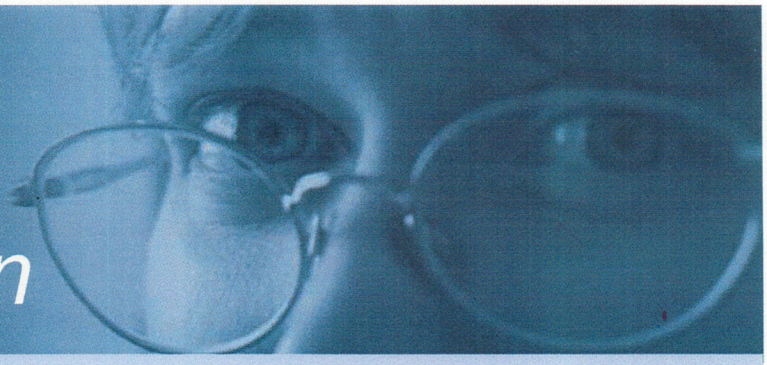
TERMINATION OF COVERAGE: Coverage terminates on the earliest of the following dates: the last day of the month in which You cease to be eligible for coverage; the last day of the month in which Your dependent is no longer a dependent, as defined; subject to the Grace Period, the last day of the month for which a premium has been paid by You or on your behalf; or the date the policy ends.

EFFECTIVE DATE: Plan effective dates are always the First of the month. Enrollment cards received by Direct Benefits after the First of the month will become effective on the First of the following month. Incomplete enrollment cards or failure to submit the required initial premium amount may cause an initial delay in Issuance of insurance. Do not cancel any other Insurance or assume You are insured under the Plan until You receive written confirmation from Direct Benefits.

Insured By:

Security Life
INSURANCE COMPANY OF AMERICA
10901 Red Circle Drive, Minnetonka, MN 55343-9137

Optional Spirit Vision Insurance Plan



Freedom to Choose Your Own Eye Care Provider

Services Offered:

Lifetime-Per Person Deductible of $50.00 on Lenses and Frames	**Maximum Covered Expense**
Examination (once every calendar year with $10 copay) A routine, complete eye examination, refraction, and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures, which are the responsibility of the member.	$50.00
Frames (once every 24 months)	$65.00
Lenses (once every 12 months)	
Single	$40.00
Bifocal	$60.00
Trifocal	$70.00
No line bifocal or progressive power OR Lenticular	$100.00
Contact Lenses (in lieu of lenses and frames)	$100.00

Monthly Premium

	To age 65	Age 65 & over
Insured only	$7.80	$9.36
Insured & 1 (child or spouse)	$14.90	$17.88
Insured & 2 or more	$19.97	$23.96

VISION EXPENSES NOT COVERED

- The cost of a lens in excess of a standard lens will not be covered. A standard lens is any lens which fits a frame with an eye size less than 61mm. Charges for replacement lenses will not be covered unless there is a change in prescription.
- The cost of a frame in excess of a standard frame will not be covered. A standard frame is any frame which has a retail value of $65.00 or less. The cost of replacement frames will not be covered, unless the existing frame is not compatible with the replacement lenses.
- In addition to the above, the following expenses are not covered:
  1. any procedure, service or supply included as a covered medical expense under any group insurance plan, whether benefits are payable as to all or only part of such charges;
  2. special procedures, such as orthoptics, vision training and subnormal vision aids;
  3. plano or prescription sunglasses or other special purpose vision aids;
  4. medical or surgical treatment of the eyes, including hospital expenses;
  5. replacement of lost or broken lenses and/or frames;
  6. duplicate glasses or lenses or frames; and
  7. services or material not listed as an Eligible Expense.

Note: *Visit any provider. Vision is available only as a rider to the Spirit Dental plan (not stand-alone). The vision rider is optional to purchase, but cannot be terminated separately from dental.*

Coverage for:

- Exams
- Frames
- Lenses
- Contact Lenses

SPIRIT VISION

For more information, call:

Direct Benefits, Inc. at 800-620-5010

S11035 (3-07)

Indemnity – Choose Your Own Dentist

Send completed form to: *Direct Benefits, Inc., 325 Cedar St., Suite 800, St. Paul, MN 55101*
phone 651-649-3503 • fax 651-649-3502

Premium rates illustrated are guaranteed for initial twelve months and may change annually thereafter.

Area	Applicant Only Under Age 65 / Age 65 and over	Applicant + 1 Under Age 65 / Age 65 and over	Applicant + Family Under Age 65 / Age 65 and over
1	31.07 / 33.32	63.38 / 68.90	90.81 / 98.99
2	34.06 / 36.53	69.98 / 75.54	100.41 / 108.53
3	37.43 / 40.14	77.40 / 83 01	111.20 / 119.27
4	41.17 / 44.16	85.65 / 91 32	123.20 / 131.19
5	45.29 / 48.57	94.72 / 100.45	136.40 / 144.31
6	49.78 / 53.39	104.62 / 110.41	150.80 / 158.63
7	54.65 / 58.61	115.34 / 121.20	166.40 / 174.13
8	60.26 / 64.63	127.72 / 133.65	184.40 / 192.02

Rates effective 04/01/10 - 01/01/11

Premiums are determined by area. To determine your monthly premium rate, refer to the Area/State charts on this page. You may choose an optional $2,000 Benefit plan for a 10% increase to the base rate.

Rate = _____
\+
[ ] Optional $2,000 benefit (rate x .10) = _____
Monthly Total = _____
[ ] Optional Vision = _____
Application Fee + $30.00
Total Remittance = $_____

Payment options include Visa/Mastercard or checking/ savings account bankdraft.

AGENT INFORMATION *(For agent use only)*

Producer Name PATRICIA FREEMAN
Street Address 15206 JOHN WEST RD.
City GONZALES State LA Zip 70737
Phone (225) 622-6554
SSN/TIN _____
EMail Address trish@insurancelady.com
Insurance License # 233647
Agent Number (if applicable) _____
Are you currently appointed with Security Life Insurance Company? [X] YES [ ] NO
License Attached? [ ] YES [X] NO
PRODUCER NAME PATRICIA FREEMAN
PRODUCER SIGNATURE Patricia Freeman
DATE _____
GENERAL AGENT _____

AREA (STATE) DEFINITIONS

Alabama		**Colorado**		**Kansas**		**Montana**		**Ohio**		**Utah**	
350-355, 359	3	803, 808-810	4	660-662	2	590-591	1	All Areas	1	All Areas	1
All Other	1	All Other	1	All Other	1	599	2	**Oklahoma**		**Virginia**	
Alaska		**Delaware**		**Kentucky**		All Other	3	740-743	2	201, 220-221	5
995-996	8	All Areas	2	All Areas	1	**Nebraska**		All Other	1	222-223	6
All Other	6	**Dist Columbia**		**Louisiana**		All Areas	1	**Oregon**		224-225, 230-232	1
Arizona		All Areas	6	707-711	2	**Nevada**		977	3	228-229, 240-244	2
856-857, 864	2	**Georgia**		712	3	890-891	2	978	1	233-237	5
All Other	1	300-303	2	All Other	1	894-895, 898	6	All Other	2	All Other	4
Arkansas		All Other	1	**Massachusetts**		All Other	4	**Pennsylvania**		**Washington**	
All Areas	1	**Hawaii**		All Areas	5	**New Jersey**		170-178, 182-187	2	982-984	4
California		All Areas	3	**Michigan**		All Areas	4	190-192	3	990-992	3
900-905	7	**Idaho**		480-483, 490-491	2	**New Mexico**		All Other	1	993	6
906-914	6	All Areas	1	488-489	3	881	2	**Rhode Island**		All Other	5
915-916	8	**Illinois**		All Other	1	882	5	029	3	**West Virginia**	
917-918	4	600-605	2	**Minnesota**		All Other	1	All Other	2	255-257	4
919-927, 930-934	6	606-608	3	553-558, 564, 566	2	**North Carolina**		**South Carolina**		262-265	3
939	6	All Other	1	All Other	1	277	2	All Areas	1	All Other	2
943-948	4	**Indiana**		**Mississippi**		286	3	**Tennessee**		**Wisconsin**	
956-958	3	463-464	2	390-392	2	287-289	2	373-374	2	All Areas	1
949, 961	6	473	3	All Other	1	All Other	1	All Other	1	**Wyoming**	
959	4	All Other	1	**Missouri**		**North Dakota**		**Texas**		All Areas	1
All Other	5	**Iowa**		640-641, 644-649	2	580-581	2	751-753	3		
		All Areas	1	All Other	1	All Other	1	754	4		
								756-757, 776-777	1		
								All Other	2		

SPIRIT DENTAL®

Please send completed form to: **Direct Benefits, Inc.**
325 Cedar Street, Suite 800
Saint Paul, MN 55101
phone: 651.649.3503 • fax: 651-649-3502

DENTAL APPLICATION

Insured By Security Life Insurance Company of America - Minnetonka, Minnesota

				/ / Mo Day Yr	M [ ] F [ ]	For Company Use Only
Email Address	Last Name	First	Initial	Birthdate	Sex	Effective Date
Home Address				Marital Status [ ] Married [ ] Single		Plan Code
City, State, Zip		Telephone:				
Billing Address (if different than the above)						Waiver / CPT

LIST DEPENDENTS TO BE COVERED (list spouse first) Last Name (if different)	First Name	Initial	Sex M F	Birthdate Mo. Day Yr	Last Name (if different)	First Name	Initial	Sex M F	Birthdate Mo. Day Yr
2. Spouse					5.				
3. Child					6.				
4.					7.				

Does Spouse have a dental plan? Yes [ ] No [ ] With whom? _____
If answer is "Yes", are dependents enrolled under spouse's 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 listed above over Age 18 are full time students:
☐ Yes ☐ No If no, who is not? _____

I am applying for coverage on:
[ ] Applicant Only [ ] Applicant + 1 [ ] Applicant + Family

Coverage Elections:
[ ] $1,200 Annual Maximum [ ] Indemnity
[ ] $2,000 Annual Maximum [ ] DHA-Premier PPO
[ ] Vision Option

BY MY SIGNATURE, I HEREBY APPLY FOR COVERAGE UNDER GROUP DENTAL INSURANCE POLICY FORM GH-1112 ISSUED TO THE VOLUNTARY GROUP TRUST.

California Law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage & for other regulators. I also certify I have read the applicable Fraud Notice on the reverse side of this form.

PATRICIA FREEMAN

Applicant's Signature — Agent Name (if applicable) — Date
GHA-1112

PAYMENT OPTIONS – $30 enrollment fee ($20 if enrolled at www.spiritdental.com)

[ ] Monthly Bank If choosing to pay monthly Bank, you must complete and sign the Authorization Agreement form and submit it along with two (2) months premium payable to Security Life Insurance Company of America/SLICA and your completed Dental Application.

[ ] Monthly Credit Card If choosing to pay by credit card, you must complete and sign the Authorization Agreement form below.

AUTHORIZATION AGREEMENT:
I hereby authorize Security Life Insurance Company of America to initiate entries to my banking or credit card account. This authorization shall remain in full force until company has received advance written notification from me to terminate. 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 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.

Name of Financial Institution _____

or [ ] Checking Account (include voided check) Account Number: _____
[ ] Savings Account (include deposit slip) Account Number: _____
[ ] Visa [ ] Master Card Card #_____ Expiration Date_____/_____/_____

Name: _____
Signature: _____ Date: _____

IMPORTANT FRAUD NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

State Specific

Arkansas/Louisiana
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

New Mexico
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime and subjects such person to criminal and civil penalties.

Tennessee/Virginia
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.