The Choice of Multiple Plan Designs

The Choice of Calendar Year Maximums

The Choice for Optional Vision Coverage

The Choice of Provider

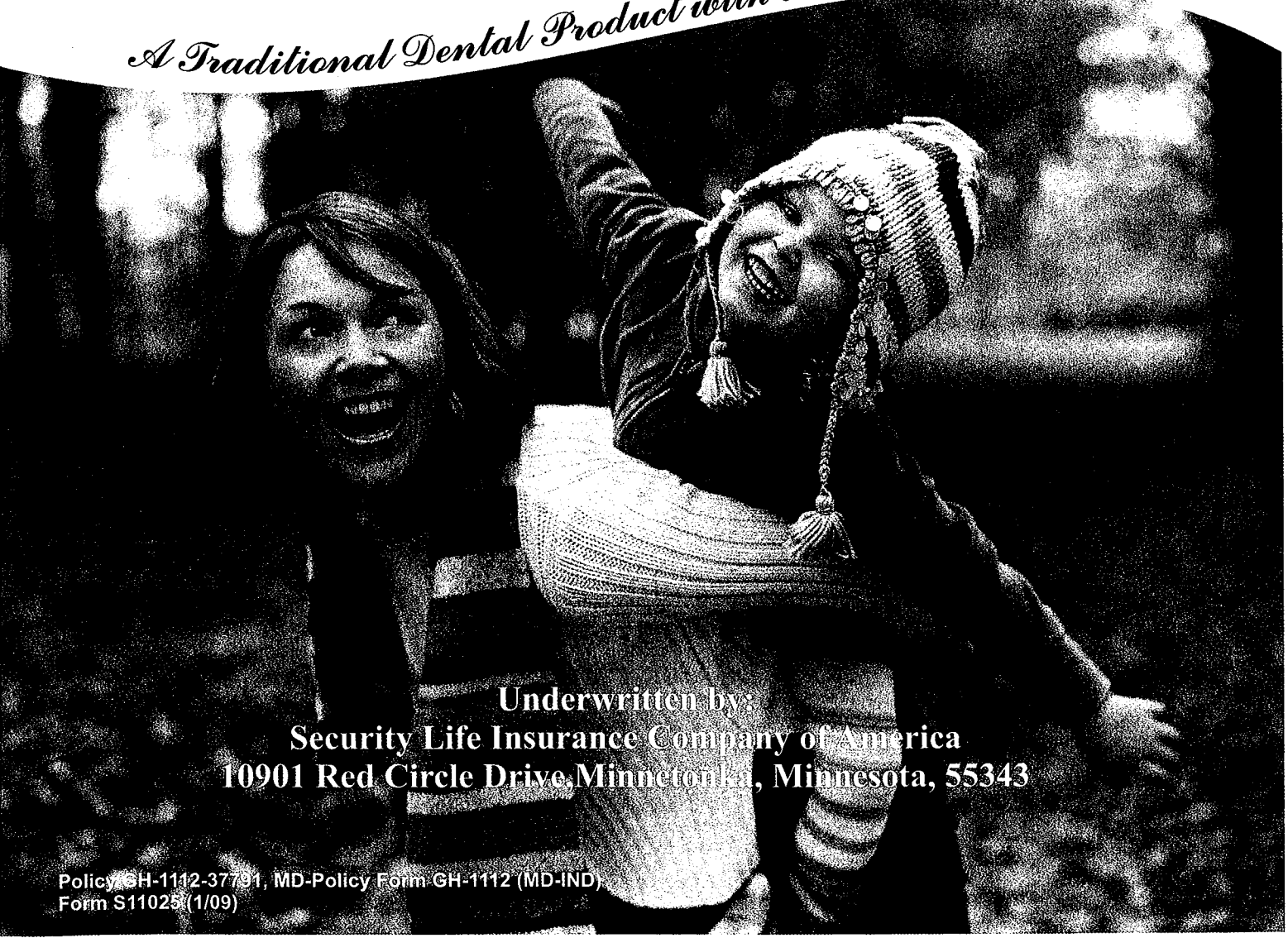
The Choice for Seniors

Free Hearing Aid Benefit Included

Security Signature

PERSONAL DENTAL PLANS

A Traditional Dental Product with a Choice for Every Need



Underwritten by:
Security Life Insurance Company of America
10901 Red Circle Drive, Minnetonka, Minnesota, 55343

Policy GH-1112-37791, MD-Policy Form GH-1112 (MD-IND)
Form S11025 (1/09)

PLAN FEATURES

ELIGIBLE EXPENSES
We will pay for Eligible Expenses You Incur for Yourself or on behalf of Your insured Dependent. Expenses must be incurred while the Policy is in force and the person is covered by the Policy. The description of Eligible Expenses is shown in the Coverage Schedule. To be an Eligible Expense, the dental service or procedure must be performed by a Dentist, a Physician or a Dental Hygienist.

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

DEDUCTIBLE AMOUNT
The calendar year Deductible, if any, is shown in the Coverage Schedule. The Deductible is an amount of eligible charges You must incur for Yourself or on behalf of Your insured Dependent before We can begin paying benefits.

CALENDAR YEAR MAXIMUM
The maximum limit payable for all Eligible Expenses in any calendar year is shown in the Coverage Schedule. The Maximum Calendar Year Limit, if any, will apply to each person covered under the Policy.

PRETREATMENT REVIEW
If the Course of Treatment will exceed the amount shown in the Coverage Schedule, 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
(Does not apply in Maryland)
If any person under this Policy (referred to as "this Plan") is also covered under one or more other plans, the benefit under this Plan will be coordinated with benefits payable under all other plans.

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.

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. The maximum We will allow will be the charges for the less expensive treatment.

ELIGIBILITY
Individuals, 18 years of age or older, 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.

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

EFFECTIVE DATE
You and Your Dependents are covered on the later of: the date We accept Your enrollment and determine an effective date; or the date You first acquire a Dependent, if the date is after Your coverage begins.

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

DENTAL EXPENSES NOT COVERED

-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 implants and 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.

Security Signature Plans are not available in South Dakota.

Dental Benefits	Option 1	Option 2	Option 3
Class A - Preventive			
Initial & Periodic Exams (2 per year)			
Cleanings (2 per year)			
All X-rays			
Sealants (to age 16)			
Fluoride Treatments (to age 16)			
Space Maintainers			
Deductible Class A	None	None	None
Waiting Period	None	None	None
Benefit Level	100%	100%	90%
Class B - Basic			
Fillings			
Simple Extractions			
Deductible Class B & C combined**	$50	$50	$50
Waiting Period	None	None	None
Benefit Level	90%	80%	70%
Class C - Major			
Oral Surgery			
Endodontics			
Periodontics			
Crowns, Bridges, Dentures			
Deductible Class B & C combined**	$50	$50	$50
Waiting Period	12 Months	12 Months	12 Months
Benefit Level	50%	50%	50%
Calendar Year Maximum for Classes A, B and C Combined (Optional $1500 Maximum Available)	$1,000	$1,000	$1,000

****Class B & C Deductible is combined for each calendar year.
A maximum of three (3) individual deductibles per family shall apply.**

Optional Vision Benefits Rider (Not a Stand Alone Benefit) Available with Option 1, Option 2 & Option 3

Optional Vision Benefits are not available in Maryland

Class A - Vision Exams - 1 per year	Class B - Lenses and Frames - 1 pair every 2 years	Class C - Contact Lenses - 1 pair every 2 years (in lieu of frames and lenses)
Benefit Level.....85%	**Benefit Level.....50%**	**Benefit Level.....50%**
Waiting Period.....None	**Waiting Period.....15 Months**	**Waiting Period.....15 Months**

Calendar Year Deductible.....$50/year
Calendar Year Maximum for Classes A, B and C.....$150

epic Hearing Health Care

As an added value feature for purchasing the Security Signature Dental Plan (you and your family members) will be eligible for valuable hearing aid benefits from the EPIC Hearing Service Plan. Security Signature Dental members can realize savings from 25 - 50% off for major brand hearing instruments. In addition, EPIC has a battery program in which they will ship the batteries directly to your home. The cost savings is greater than 40% from standard retail store pricing. To learn more about this valuable benefit visit www.epichearing.com/SLI.

The EPIC Hearing Service Plan is not insurance but EPIC will coordinate any Managed Medicare or Insurance supplemental programs to help reduce your out-of Pocket costs.

QUESTIONS? PLEASE CONTACT YOUR AGENT

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 $75.00 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.

IMPORTANT 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 Contract. Some provisions may vary by state. Security Signature Dental Plans may not be available in all states.

For applicants in all states (except Maryland), a full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Policy Form GH-1112-37791 issued to the Voluntary Group Trust.

For applicants in Maryland, a full explanation of benefits, exceptions and limitations is contained in Policy Form GH-1112 (MD-IND).

No agent has the authority to change any benefits, to bind coverage with Security Life Insurance Company of America, or to promise a certain effective date.

SECURITY SIGNATURE PERSONAL DENTAL RATES

For effective dates February 1, 2009 through August 1, 2009

Monthly Premiums illustrated are guaranteed for initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on an annual basis

Rate Chart			Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
UNDER AGE 65	Option 1	Applicant Only	$ 43.07	$ 47.67	$ 52.26	$ 57.43	$ 63.18	$ 69.49	$ 76.39	$ 83.85
		Applicant + One	$ 84.82	$ 93.87	$ 102.92	$ 113.10	$ 124.40	$ 136.85	$ 150.42	$ 165.12
		Family	$ 144.08	$ 159.45	$ 174.82	$ 192.11	$ 211.32	$ 232.45	$ 255.51	$ 280.48
	Option 2	Applicant Only	$ 34.91	$ 38.63	$ 42.35	$ 46.54	$ 51.19	$ 56.31	$ 61.90	$ 67.95
		Applicant + One	$ 68.74	$ 76.07	$ 83.40	$ 91.65	$ 100.81	$ 110.89	$ 121.89	$ 133.81
		Family	$ 116.76	$ 129.21	$ 141.67	$ 155.68	$ 171.25	$ 188.37	$ 207.05	$ 227.29
	Option 3	Applicant Only	$ 32.30	$ 35.75	$ 39.19	$ 43.07	$ 47.38	$ 52.11	$ 57.28	$ 62.88
		Applicant + One	$ 63.61	$ 70.39	$ 77.18	$ 84.81	$ 93.29	$ 102.62	$ 112.80	$ 123.82
		Family	$ 108.05	$ 119.57	$ 131.10	$ 144.07	$ 158.47	$ 174.32	$ 191.61	$ 210.34
65 AND OVER	Option 1	Applicant Only	$ 47.38	$ 52.44	$ 57.49	$ 63.18	$ 69.49	$ 76.44	$ 84.02	$ 92.24
		Applicant + One	$ 93.30	$ 103.26	$ 113.21	$ 124.40	$ 136.85	$ 150.53	$ 165.46	$ 181.63
		Family	$ 158.49	$ 175.40	$ 192.30	$ 211.32	$ 232.45	$ 255.70	$ 281.06	$ 308.53
	Option 2	Applicant Only	$ 38.40	$ 42.49	$ 46.59	$ 51.19	$ 56.31	$ 61.95	$ 68.09	$ 74.74
		Applicant + One	$ 75.61	$ 83.67	$ 91.74	$ 100.81	$ 110.89	$ 121.98	$ 134.08	$ 147.19
		Family	$ 128.43	$ 142.13	$ 155.83	$ 171.25	$ 188.37	$ 207.21	$ 227.76	$ 250.02
	Option 3	Applicant Only	$ 35.53	$ 39.32	$ 43.11	$ 47.38	$ 52.11	$ 57.33	$ 63.01	$ 69.17
		Applicant + One	$ 69.97	$ 77.43	$ 84.90	$ 93.29	$ 102.62	$ 112.88	$ 124.08	$ 136.21
		Family	$ 118.85	$ 131.53	$ 144.21	$ 158.47	$ 174.32	$ 191.75	$ 210.77	$ 231.37
OPTIONAL VISION COVERAGE FOR ALL AGES		Applicant Only	$ 6.62	$ 6.62	$ 6.62	$ 6.62	$ 6.62	$ 6.62	$ 6.62	$ 6.62
		Applicant + One	$ 12.57	$ 12.57	$ 12.57	$ 12.57	$ 12.57	$ 12.57	$ 12.57	$ 12.57
		Family	$ 18.46	$ 18.46	$ 18.46	$ 18.46	$ 18.46	$ 18.46	$ 18.46	$ 18.46

SEE SEPARATE RATE SHEETS FOR: CO, DC, KY, MD, NM, NC, ND, OH, PA, TN, VA, WA

Zip Code Chart

State		State		State		State		State		State		State		State	
Zip	Area	Zip	Area	Zip	Area	Zip	Area	Zip	Area	Zip	Area	Zip	Area	Zip	Area
Alabama		California		Georgia		Indiana		Massachusetts		Missouri		Oklahoma		Utah	
350-351	1	902-908	5	310	2	462-464	3	010-011	4	641	3	747-749	1	842-847	1
354-355	1	913	5	311	5	All Other	2	012	3	644-647	1	All Other	2	All Other	2
359	1	919-921	5	312	2	Iowa		013-015	5	653-655	1	Oregon		West Virginia	
360-361	1	926,928	5	316-319	2	504-508	1	020	5	All Other	2	978-979	2	260	1
362-364	1	931	7	398	2	512-517	1	023	5	Montana		All Other	3	265	1
367-368	1	932-934	3	All Other	3	521	1	024	7	590	2	South Carolina		All Other	2
All Other	2	935	5	Hawaii		All Other	2	027	4	592-597	2	293	2	Wisconsin	
Alaska		939-940	5	All Areas	3	Kansas		All Other	6	599	2	295	2	530-532	3
995-997	6	941	6	Idaho		661-662	3	Minnesota		All Other	3	All Other	3	534	3
All Other	5	943-944	6	All Areas	2	664-665	1	550	3	Nebraska		South Dakota		543	4
Arizona		945-951	5	Illinois		667-669	1	551	4	680	1	Not Available		All Other	2
850	4	All Other	4	601-603	4	670-671	1	553-555	4	683-684	1	Texas		Wyoming	
852	4	Delaware		604	3	673-679	1	561-562	1	686-693	1	750-751	4	All Areas	2
All Other	3	197-198	5	605-608	4	All Other	2	All Other	2	All Other	2	752-753	5		
Arkansas		All Other	3	611	3	Louisiana		Mississippi		Nevada		760-763	3		
716-721	1	Georgia		619	1	701	3	386	1	893-895	4	770	4		
723-724	1	301-302	4	624-626	1	All Other	2	All Other	2	897-898	4	772-773	4		
728	1	303	5	628	1	Michigan		Missouri		All Other	3	774-775	3		
All Other	2	307	2	All Other	2	484-485	2	630-631	3	Oklahoma		786-787	4		
						488-499	2	633-634	3	734-735	1	All Other	2		
						All Other	3	635-639	1	743-745	1				

Security Life Insurance Company of America, Minnetonka, MN
Security Signature Personal Application

MAIL - the application along with initial payment to:
Security Signature Personal Plans
10901 Red Circle Drive, Suite 400
Minnetonka, MN 55343

Questions? Please call (866) 847-1120

Plan Selection: ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Under Age 65 ☐ Senior (65 or older) ☐ Vision Option
☐ Increase Calendar Year Maximum to $1 500
I apply for coverage on: ☐ Applicant Only ☐ Applicant +1 ☐ Family

APPLICANT INFORMATION (PLEASE PRINT CLEARLY

Last Name	First Name	Initial		Birth Date: / /
Address		Telephone Number		Sex: M☐ F☐
City		State	Zip	Marital Status
Billing Address (If Different)	City	State	Zip	Married ☐ Single ☐

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					

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 RATES

1. Locate the first three digits of your zip code on the **Zip Code Area Chart** found on the reverse side of this application. Using the corresponding area number. determine the applicable monthly premium, found on the **Rate Chart** on the reverse side of this application, based upon your eligibility age, plan selection and coverage type.

2. Select your mode of payment

☐ **Monthly - Bank Account Debit (ACH)** (Checking or Savings) Complete Authorization Agreement below and submit one (1) month premium
Checking Acct. - Attach voided check - DO NOT SUBMIT DEPOSIT SLIP
Savings Acct. - Attach savings deposit slip with account number including the bank routing number.

☐ **Monthly Credit Card**
Complete Authorization Agreement below. Initial premium will be charged to your card the first of next month
☐ Visa ☐ Master Card
Card # _____ Expiration Date _____/____/_____

☐ **Quarterly Direct Bill** - submit three (3) months premium

☐ **Semi-Annual Bill** - submit six (6) months premium

Monthly Rate (found on the Premium Rate Table)	Optional $1500 Calendar Yr Max X 1.10	Vision Add-on (found on the Premium Rate Table) +	Sub Total: =	Multiply by 3 if electing quarterly payment mode or 6 f electing semi-annual payment mode	$5 Billing Fee applies if Quarterly or Semi Annual Mode is Selected +	Total Remittance
$	$	$	$	X		$

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 Holders Signature

FOR AGENT USE ONLY - Please Print Clearly

Producer Name Michael W. Smith	Producer Phone # 763-535-7293		
Street Address 5261 Florida Avenue North	City Crystal	St MN	Zip 55428
Producer Email mwsmith@insuremn.com	Producer SS#/TIN# ***-**-0166		
Appointed with Security Life? ☒ Yes ☐ No	Producer Signature Michael W. Smith		

FOR COMPANY USE ONLY

Effective Date: ____/____/____

Plan Code: _____ **SLIC**

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.

Fraud Notice - 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 maybe subject to fines and confinement in prison.

By my signature below, I hereby apply for coverage under Group Dental Insurance Policy GH-1112-37791 issued to the Voluntary Group Trust. I also certify I have read the applicable Fraud Notice above.

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**