

BROKERS NATIONAL LIFE ASSURANCE

CIRCLE OF HEALTH HAS FOUND A DENTAL AND VISION GROUP THAT WILL ALLOW BAND MEMBER'S TO THE CURRENT POLICY.

Below are the steps to sign up for the coverage, the policy WILL NOT be active until the 1st of the following month.

- Fill out the form completely, making sure to include any dependants
- If today's date isn't past the 25th of the month, you can use the 1st of the following month for **Requested Effective Date**
- Make sure to include an active phone number, so Circle of Health staff can contact you if there are any questions
- The premiums will be billed to our office, if you obtain employer's insurance make sure to let your claims processor know to remove you from this policy
- Please take the brochure which explains your coverage, and please note that some services are uncovered the first benefit year or have maximum benefits. If you go ahead with a procedure that is not covered, it will be your responsibility to pay the bill. Circle of Health does not pay on any services not covered by a primary, or once the maximum amount has been met.
- Return the completed form to clinic personnel who will forward the original enrollment form to our office, to process immediately.
- Approximately 30 days later you should receive your dental/vision card, make sure to make a copy and submit to our office for your file. When making any appointments ask first what will be covered.
- The vision coverage is only by certain providers and only for the exam, band members can utilize their additional benefit for glasses up to \$250. Any other amounts are the band member's responsibility. This benefit needs to be pre-authorized by Circle of Health Staff.

THIS POLICY IS ONLY FOR DENTAL AND VISION, IF YOU DO NOT HAVE ANY MEDICAL COVERAGE YOU WILL NEED TO FOLLOW THE NECESSARY STEPS TO OBTAIN A PRIVATE POLICY. CALL OUR OFFICE AND ASK FOR THE BENEFIT COORDINATOR FOR ASSISTANCE.

OR GO TO A LOCAL INDEPENDENT INSURANCE AGENT WHO CAN ASSIST YOU IN SIGNING UP FOR A BCBS POLICY AND FINALLY CONTACT OUR OFFICE REGARDING THE PREMIUM PAYMENTS, CALL OUR OFFICE AND SPEAK TO THE BENEFIT COORDINATOR WHO HAS NAMES, AND NUMBERS FOR YOUR AREA.

IT IS ALWAYS BEST TO PHONE AHEAD BEFORE COMING TO OUR OFFICE OR THE INSURANCE AGENCY.

We have a PLAN for YOU...

Edge Plus Dental

Protect your smile with Edge Plus dental insurance. Good dental hygiene will help you maintain healthy teeth and reduce the possibility of expensive dental procedures.

Getting Coverage is as easy as 1, 2, 3.

1. **Guaranteed Issue** – No Industry Limitations
2. **Completely Voluntary**
3. **Minimum Enrollment of Only 3 full-time Employees** (In Tennessee, minimum of 2 employees) (No more than 50% of the insured group can be direct relatives, unless we are provided with a quarterly Wage and Tax Report that proves the relatives work for the Policyholder.)

Edge Plus offers:

- Choose Any Dentist.**
- Full Coverage** for preventive procedures
- Immediate Coverage** – for preventive procedures, simple extractions, fillings, oral surgery, and root canals
- Benefits up to \$1,500 Annually** for every family member

\$1,000 Lifetime Orthodontia benefits for dependent children age 6-18 begins in third benefit year. ***

Other Benefits:

Rates are **Guaranteed for 12 months** from the Group's Original Effective Date.

Annual Open Enrollment Period

Can be used as part of a Section 125 Cafeteria Program

Family Coverage for spouse and dependent children

Maximum of 3 Deductibles per Family (\$150) per benefit year. Benefit year deductibles are combined for Types II & III procedures.

Takeover and Variations of the Plan
Require a Quote from the Home Office.
 Call 1-800-798-1125.

Dependent children is defined as unmarried dependent children up to age 19 or up to age 23 if the child is a full time student; dependent on the employee for support.
 (Except as described below):

- Georgia** – Unmarried dependent children up to age 19 or up to age 26 if the child is a full time student; dependent on employee for support.
- Louisiana** – Unmarried dependent children up to age 21 or up to age 24 if the child is a full time student; dependent on employee for support.
- Minnesota** – Unmarried dependent children up to age 25.
- New Mexico** – Unmarried dependent children up to age 25, regardless of whether the dependent is enrolled in an educational institution.
- North Dakota** – Unmarried dependent children up to age 22 or up to age 26 if the child is a full time student; dependent on employee for support.
- Tennessee** – Unmarried dependent children up to age 25; dependent on employee for support.
- Utah** – Unmarried dependent children up to age 26; dependent on employee for support.

EDGE PLUS (PLAN A) BENEFITS

* Standard Benefits	First Benefit Year	Second Benefit Year	Third Benefit Year after
TYPE I Preventive Procedures: Fluoride Treatments (under age 19), X-Rays, Cleanings, Periodic Exams Benefit Year Deductible Company Pays	0	0	0
TYPE II Basic Restorative Procedures: Simple Extractions, Simple Oral Surgery, Fillings, Root Canals Benefit Year Deductible Company Pays	100%	100%	100%
TYPE III Major Restorative Procedures: Removal of Impacted Teeth, Bridges, Crowns, Dentures, Partials Benefit Year Deductible Company Pays	80%	80%	80%
TYPE IV *** Age 6-18 *** Orthodontia Benefits Lifetime Deductible Company Pays Lifetime Benefits Orthodontia Only	Not Covered	Not Covered	50%
Maximum Benefit Year Type I, II and III	\$750	\$1,000	\$1,500
Maximum Benefit Year Type I, II and III	Not Covered	50%	50%

* See policy/certificate for complete coverage details.
 ** **Paragymnasia of Oregon** – Type IV – Orthodontia benefits are covered in the 2nd year.
 *** To age 21 in Louisiana
 Benefits are based upon the usual and customary fees charged in the area where service is rendered. Benefit Year maximums are calculated for each Certificate Year from Certificate Effective Date.
 Late Enrollor Penalty: Benefit year maximum during the first 12 months for late enrollers is \$200 per covered person. Coverage is limited to routine exams, prophylaxis, and x-rays for the first 6 months.

BROKERS NATIONAL LIFE ASSURANCE COMPANY ENROLLMENT CARD

		BROKERS NATIONAL LIFE ASSURANCE COMPANY		GROUP DENTAL INSURANCE ENROLLMENT CARD			
NAME OF EMPLOYER _____				GROUP # _____			
EMPLOYEE NAME LAST _____	FIRST _____	MIDDLE _____	SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE				
HOME ADDRESS STREET _____	CITY _____	STATE _____	ZIP CODE _____				
HOME TEL. NO. () _____	DATE OF BIRTH / / _____	SOCIAL SECURITY NUMBER _____		EMPLOYMENT DATE _____			
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		(CHECK ONE): <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE AND ONE DEPENDENT <input type="checkbox"/> EMPLOYEE AND FAMILY		WORK 30 HOURS PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
LIST NAME, SEX, AND DATE OF BIRTH OF EACH DEPENDENT YOU WISH TO INSURE STUDENT VETERANS/ARMY RESERVE/DEPENDENTS OVER 18							
NAME	REL.	SEX	DATE OF BIRTH	NAME	REL.	SEX	DATE OF BIRTH
DOES YOUR SPOUSE HAVE OTHER COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS THE AMOUNT TO COVER MY SHARE OF THE CONTRIBUTION FOR COVERAGE INDICATED ABOVE PROVIDED ON THIS RETURN AND ACCEPTED		<input type="checkbox"/> FULLY PAID PLAN <input type="checkbox"/> EMPLOYER PAID			
SIGNATURE OF EMPLOYEE _____		DATE _____	REQUESTED EFFECTIVE DATE _____		(CHECK ONE): <input type="checkbox"/> PLANA <input type="checkbox"/> PLANB <input type="checkbox"/> BASIC		
E-4447200400114		DOWBOILED IN THE STATE OF ARIZONA - ADMINISTRATIVE OFFICE 1018 MAY 11 WEST, S.T.E. 100, AUSTIN, TEXAS 78716 - PHONE: 817 288 8200					

Please fill out name, indicate sex, address, home telephone, date of birth, social security number. Below list any dependants you would like on this policy. Make sure to sign and date. Our office will fill out the other required fields. There is also a Brokers Change form, please contact the Circle of Health office to make any changes including dependent coverage. This additional form will also need to be filled out to terminate your coverage, in cases where an employer dental insurance plan is obtained