PLEASE NOTE

The attached brochure and application is for the state of Maryland.

IMPORTANT NOTICE

Security Life Dental Insurance is marketed by licensed agents. This brochure must be completed through a licensed agent and submitted to the Company by a licensed agent.

If you are interested in purchasing a Security Life dental plan and you do not have agent representation, please contact us at (866) 847-1120.

We will connect you with a qualified individual who can help you find the dental plan that best meets your needs.

PrimeStar®
Personal Dental Insurance Plans

Underwritten by Security Life Insurance Company of America,
10901 Red Circle Dr., Minnetonka, Minnesota, 55343

★ No Enrollment Fee
★ Optional Vision Coverage
★ Includes Coverage for All Ages
★ Freedom to Choose Any Dentist
★ Up to $2,000 Annual Maximum
★ No Waiting Periods for Most Services

Dental Benefits

Class A - Preventive Services	Elite	Premier	Select
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (to age 16), Sealants (no age limitation)			
Benefit Year One	100%	100%	75%
Benefit Year Two	100%	100%	85%
Benefit Year Three and Each Benefit Year Thereafter	100%	100%	100%
Deductible - Lifetime per Insured	$50	$50	$50
Class B - Basic Services	**Elite**	**Premier**	**Select**
X-rays, Fillings, Simple Extractions			
Benefit Year One	35%	35%	25%
Benefit Year Two	65%	50%	35%
Benefit Year Three and Each Benefit Year Thereafter	80%	65%	50%
Deductible - Each Calendar Year per Insured*	$50/yr	$50/yr	$50/yr
Class C - Major Services	**Elite**	**Premier**	**Select**
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Year One	15%	10%	10%
Benefit Year Two	50%	25%	25%
Benefit Year Three and Each Benefit Year Thereafter	50%	50%	50%
Deductible - Each Calendar Year per Insured*	$50/yr	$50/yr	$50/yr
Class D - Orthodontic Services	**Elite**	**Premier**	**Select**
Straightening of Teeth (for children under age 19)	Not		Not
Benefit Year One	Available	0%	Available
Benefit Year Two	Under	0%	Under
Benefit Year Three and Each Benefit Year Thereafter	This Plan	50%	This Plan
Calendar Year Maximums			
Calendar Year Maximum for Classes A, B and C Combined	$1,000	$1,000	$1,000
Calendar Year Maximum for Class C - Major Services	$500	$500	$500
Calendar Year Maximum for Class D	-	$500	-
Lifetime Maximum Per Child for Class D	-	$1,000	-
Calendar Year Maximum Increase Option			
You may increase the Calendar Year Maximum benefit, per individual, for an additional monthly fee			
Option 1 - Increase Classes A, B & C to $1,500 with Class C Major Services limited to $750			
Option 2 - Increase Classes A, B & C to $2,000 with Class C Major Services limited to $1,000			

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

WAITING PERIODS Class A, B & C None, Class D Orthodontics - 24 months

Optional Vision Benefits Rider

Class A - Vision Exams - 1 per year	Elite	Premier	Select
Benefit - (Waiting Period - None)	100%	85%	85%
Class B - Lenses and Frames - 1 pair every 2 years			
Benefit - (Waiting Period - 15 Months)	50%	50%	50%
Class C - Contact Lenses - 1 pair every 2 years (in lieu of frames and lenses)			
Benefit - (Waiting Period - 15 Months)	50%	50%	50%
Calendar Year Deductible	$50/yr	$50/yr	$50/yr
Calendar Year Maximum for Classes A, B and C	$200	$150	$150

Three Ways to Enroll

Online
Enrollment is available online by visiting our website at www.starsdental.com/quote. Online enrollment requires an agent authorization number (AAN). This 8-digit number can be obtained from your agent or by calling 866-847-1120.

Fax
For your convenience we accept enrollment by Fax. Complete the enrollment form and fax to our administrative team. (See full instructions on the enrollment form).

Mail
Complete the enrollment form and mail to our office. (See full instructions on the enrollment form).

- Vision rider is not a standalone benefit.
- State Exceptions: Premier Plan is not available in South Dakota. Optional Vision Benefits are not available in Maryland or South Dakota.
- The plans provide for an increase in coinsurance levels based upon each Benefit Year of coverage. Benefit Year begins with each insured's effective date and continues for 12 months. Each primary insured and dependent will have their own Benefit Year beginning with their specific effective date of coverage.
- This plan reimburses at the percentages shown for covered dental expenses based upon the Reasonable and Customary (R&C) fees for those covered expenses. Reasonable and Customary means the usual, customary and regular charges for the area where such expenses are incurred.

For more information contact:

Associated Insurance Plans International, Inc.

Policy GH-1112-38060, MD - Policy Form GH-1112 (MD-IND), SD - Policy Form GH-1112 (SD-IND) Form S11225 SLIC 05/2010

IMPORTANT INFORMATION

ELIGIBILITY

Individuals, 18 years of age or older, plus their eligible dependents (spouse and/or unmarried children from birth to age 19; extended to age 23 if child is a full-time student). This is subject to individual state regulations.

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.

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 alternate treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charges for the less expensive treatment.

COORDINATION OF BENEFITS

This Plan will be coordinated with any other group, blanket or franchise plan under which an Individual will receive benefits.

Dental Insurance Protection for You and Your Family

DENTAL EXCLUSIONS AND LIMITATIONS

- Charges in excess of those considered Reasonable and Customary
- Cosmetic procedures
- The replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function
- Implants and for replacement of lost or stolen appliances, replacement of retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication
- 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.
- Overdentures and associated procedures
- Oral hygiene instructions, and for: plaque control, completion of a claim form, acid etch, broken appointments, prescription or take-home fluoride, or diagnostic photographs
- Services not completed by the end of the month in which coverage ends unless continuation of coverage has been requested and accepted by Us
- Procedures that are begun, but not completed
- Services and treatment provided without charge, or for which there would be no charge in the absence of insurance
- 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
- 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
- The treatment of cleft palate and anodontia
- Services or supplies payable under any medical expense plan
- Orthodontia, unless included within the Coverage Schedule
- Services rendered prior to the date the Insured is covered under the Policy
- The diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD)
- Hospital services
- 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 and
- Charges for infection control, sterilization, and waste disposal.

VISION EXCLUSIONS AND LIMITATIONS

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:

- 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;
- Special procedures, such as orthoptics, vision training and subnormal vision aids;
- Plano or prescription sunglasses or other special purpose vision aids:;
- Medical or surgical treatment of the eyes including hospital expenses;
- Replacement of lost or broken lenses and/or frames;
- Duplicate glasses or lenses or frames; and
- Services or materials not listed as an Eligible Expense.

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. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance under Group Policy Form GH-1112. A specimen copy is available upon request.

Some provisions may vary by state. This Dental Plan may not be available in all states.

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 Life Insurance Company of America, Minnetonka, MN

PrimeStar Enrollment Form
Maryland

Plan Selection: ❒ **Elite** ❒ **Premier** ❒ **Select**

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

Optional Calendar Year Maximum Increase Selection ❒ **$1,500** ❒ **$2,000**

APPLICANT INFORMATION (PLEASE PRINT CLEARLY)				
Last Name	First Name	Initial		Birth Date / /
Address		Telephone Number		Sex: M ❒ F ❒
City		State	Zip	Marital Status Married ❒ Single ❒
Billing Address (If Different)	City	State	Zip	

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW					
Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date
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 ❒

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

IMPORTANT INFORMATION

Effective Date – The effective date is the first of the month following the day in which the application is received in the Service Center Office.

Identification Card and Certificate of Insurance - 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.

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

By my signature below, I hereby apply for coverage with Security Life Insurance Company of America, Minnetonka, MN under Group Dental Insurance Policy GH-1112 (MD-IND). I also certify I have read the Fraud Notice above.

Applicant Signature_____ **Date**_____

Please refer to the reverse side for payment options and agent information

PRIMESTAR PREMIUM RATE CALCULATION AND AUTHORIZATION AGREEMENT

The following sections must be completed and signed by the applicant and agent

CALCULATE YOUR RATES:

1. Locate the first three digits of your zip code on the **Rate Chart** found on the **Premium Rate Table**. Determine the applicable monthly premium, 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 two (2) months 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.

❒ Visa ❒ Master Card
Card # _____ Expiration Date _____/____/_____

❒ **Quarterly Direct Bill** – submit three (3) months premium

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

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)	**Optional Calendar Year Maximum 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	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 Holder's Signature**

FOR AGENT USE ONLY – Please Print Clearly

Producer Name Terese Harkins	Producer Phone # (800) 452-5772		
Street Address 28085 Ashley Circle Suite 201	City Libertyville	St IL	Zip 60048
Producer Email office@aipinternational.com	Producer SS#/TIN#		
Appointed with Security Life? ❒ Yes ❒ No	Producer Signature		

For your convenience there are three ways to enroll in the PrimeStar Personal Dental Plan. Please choose one of the following:

ONLINE - Visit www.AIPstudentinsurance.com and Go to the bottom of the page and select Student Dental & Vision Insurance Plan; If you need any assistance please call (800) 452-5772

FAX - the application to 847-281-8813 (You must choose Credit Card or ACH payment options)

MAIL - the application along with initial payment to:
Student Insurance Plans
P.O. Box 189
Libertyville, IL 60048

FOR COMPANY USE ONLY **Effective Date: _____/_____/_____ Plan Code: _____**

PRIMESTAR PERSONAL DENTAL

PREMIUM RATE TABLE
FOR
MARYLAND

For effective dates March 1, 2010 through October 1, 2010

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

RATE CHART			Zip Codes 206-207 209-211	Zip Code 217	All Other Zip Codes
UNDER AGE 65	ELITE	Applicant Only	$ 30.00	$ 32.00	$ 36.00
		Applicant+Spouse	$ 61.00	$ 67.00	$ 75.00
		Applicant+ Child(ren)	$ 66.00	$ 73.00	$ 79.00
		Applicant + Family	$ 103.00	$ 113.00	$ 124.00
	PREMIER	Applicant Only	$ 25.00	$ 27.00	$ 30.00
		Applicant+Spouse	$ 51.00	$ 56.00	$ 63.00
		Applicant+ Child(ren)	$ 60.00	$ 66.00	$ 72.00
		Applicant + Family	$ 91.00	$ 100.00	$ 110.00
	SELECT	Applicant Only	$ 23.00	$ 25.00	$ 26.00
		Applicant+Spouse	$ 46.00	$ 49.00	$ 56.00
		Applicant+ Child(ren)	$ 47.00	$ 51.00	$ 56.00
		Applicant + Family	$ 75.00	$ 82.00	$ 90.00
65 AND OVER	ELITE	Applicant Only	$ 32.00	$ 36.00	$ 40.00
		Applicant+Spouse	$ 67.00	$ 75.00	$ 81.00
	PREMIER	Applicant Only	$ 27.00	$ 30.00	$ 34.00
		Applicant+Spouse	$ 56.00	$ 63.00	$ 68.00
	SELECT	Applicant Only	$ 25.00	$ 26.00	$ 29.00
		Applicant+Spouse	$ 49.00	$ 56.00	$ 61.00