

PLEASE NOTE

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

IMPORTANT NOTICE

Symetra 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 Symetra 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[®] Platinum

Senior Dental Insurance Plans

Insured by Symetra[®] Life Insurance Company
 777 108th Avenue NE, Bellevue, Washington 98004
 Symetra[®] and the Symetra Financial logo are registered service marks of
 Symetra Life Insurance Company

★ 3 Cleanings Per Year

★ 100% Preventive Coverage

★ Freedom to Choose Any Dentist

★ Up to \$2,000 Annual Maximum

Choose the plan that is right for you.

Plan I - Waiting Period

Class A - Preventive Services
*Initial & Periodic Exams (2 per year),
 Cleanings (3 per year)*

Benefit Level.....100%
 Deductible per Insured.....None
 Waiting Period.....None

Class B - Basic Services
Fillings, X-Rays, Simple Extractions

Benefit Level.....80%
 Deductible per Insured.....\$50/Year*
 Waiting Period.....6 Months

Class C - Major Services
*Endodontics, Oral Surgery, Periodontics, Crowns,
 Bridges, Dentures*

Benefit Level.....50%
 Deductible per Insured.....\$50/Year*
 Waiting Period.....15 Months

Calendar Year Maximum for
 Classes A, B and C Combined.....\$1000 or \$2000
 Class C (Major Services) \$500 or \$1000

* Class B & C Deductible is combined for each
 calendar year.

Plan II - Graded Benefit

Class A - Preventive Services
*Initial & Periodic Exams (2 per year),
 Cleanings (3 per year)*

Benefit Level Year One.....100%
 Benefit Level Year Two.....100%
 Benefit Level Year Three & Each Thereafter..100%
 Deductible per Insured.....\$50/Year*
 Waiting Period..... None

Class B - Basic Services
Fillings, X-Rays, Simple Extractions

Benefit Level Year One.....35%
 Benefit Level Year Two.....50%
 Benefit Level Year Three & Each Thereafter.... 65%
 Deductible per Insured..... \$50/Year*
 Waiting Period.....None

Class C - Major Services
*Endodontics, Oral Surgery, Periodontics, Crowns,
 Bridges, Dentures*

Benefit Level Year One.....10%
 Benefit Level Year Two.....25%
 Benefit Level Year Three & Each Thereafter.... 50%
 Deductible per Insured.....\$50/Year*
 Waiting Period.....None

Calendar Year Maximum for
 Classes A, B and C Combined.....\$1000 or \$2000
 Class C (Major Services) \$500 or \$1000

* Class A, B & C Deductible is combined for each
 calendar year.

These plans reimburse at the above percentages for covered dental expenses based upon the Reasonable and Customary (R&C) fees for those covered expenses.

Free Hearing Aid Benefit



As an added value feature for purchasing the PrimeStar Platinum Senior Dental Plan, you and your family members will be eligible for valuable hearing aid benefits from the EPIC Hearing Service Plan. PrimeStar Platinum Senior 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.

For more information contact:



Important Information

ELIGIBILITY

Individuals, 60 years of age or older, plus their eligible dependent spouse. This is subject to State requirements.

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.

REASONABLE AND CUSTOMARY

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

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 or sealants
- 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.

Three Ways to Enroll Online

Enrollment is available online by visiting our website at www.starsdental.com/platinum.

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).

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 LGC-8854 2/04. 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 Symetra Life Insurance Company or to promise a certain effective date.

Symetra® Life Insurance Company

PrimeStar Platinum Senior Enrollment Form

Vermont

Plan Selection

- Plan I - Waiting Period Plan
 Plan II - Graded Benefit Plan

**Calendar Year
Maximum Choice**

- \$1,000
 \$2,000

I apply for coverage on:

- Applicant Only
 Applicant and Spouse

APPLICANT INFORMATION (PLEASE PRINT CLEARLY)

Last Name		First Name		Initial		Birth Date / /	
Address				Telephone Number		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	
City				State		Zip	
Billing Address (If Different)		City		State		Zip	
				Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/>			

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date
Spouse					/ /

Does Spouse have a dental plan: Yes No With Whom? _____

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 may be subject to fines and confinement in prison.

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 Symetra Life Insurance Company. Please allow 3-4 weeks for processing.

By my signature below, I hereby apply for coverage with Symetra Life Insurance Company, 777 108th Avenue NE, Bellevue, WA, 98004 under Dental Insurance Policy Form LGC-9041 1/05. I also certify I have read the Fraud Notice above.

Applicant _____ Date _____

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

PRIMESTAR PLATINUM SENIOR 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 **Zip Code Area Chart** found on the **Premium Rate Table**. Using the corresponding area number, 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 **Symetra Life Insurance Company** 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)	Multiply by 2,3 or 6 depending upon mode of payment selected above	Total Remittance
\$	X	\$

For Initial payment, make check payable to Symetra Life Insurance Company

AUTHORIZATION AGREEMENT: (When paying by ACH or Credit Card please complete the section below)

As a convenience to me, I authorize Symetra Life Insurance Company to initiate entries to my bank account or credit card account for my monthly dental. 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 Symetra Life Insurance Company has received written notice from me that it should be cancelled. I understand that I have the right to stop payment by notification to Symetra Life Insurance Company, 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		Producer Phone #		
Street Address		City	St	Zip
Producer Email		Producer SS#/TIN#		
Appointed with Symetra Life? <input type="checkbox"/> Yes <input type="checkbox"/> No		Producer Signature		

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

ONLINE – Visit www.StarsDental.com/platinum and follow the step by step instructions
Agent Authorization Number (Required for Online purchases) (AAN) _____

FAX - the application to 518-348-7728 (You must choose Credit Card or ACH payment options)

MAIL - the application along with initial payment to:
PrimeStar Platinum Dental Administration Office
P.O. Box 1064
Schenectady, NY 12301

FOR COMPANY USE ONLY

Effective Date: ____/____/____ Plan Code: _____ SLIC

**PRIMESTAR PLATINUM SENIOR DENTAL PLAN
PREMIUM RATE TABLE**

Vermont

FOR EFFECTIVE DATES APRIL 1, 2010 THROUGH NOVEMBER 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.

Waiting Period Plan 1	\$1,000 annual Maximum	Area 1
	Applicant Only	\$ 44.75
	Applicant and Spouse	\$ 89.00
	\$2,000 Annual Maximum	Area 1
	Applicant Only	\$ 49.50
	Applicant and Spouse	\$ 99.25
Graded Benefit Plan 2	\$1,000 annual Maximum	Area 1
	Applicant Only	\$ 35.25
	Applicant and Spouse	\$ 70.75
	\$2,000 Annual Maximum	Area 1
	Applicant Only	\$ 40.00
	Applicant and Spouse	\$ 80.00

ZIP CODE AREA CHART	
VERMONT	
Zip	Area
All Areas	1