Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 8189875000 fax: (818) 776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly.

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana, CA 91356

Please make your check payable to: Security Life Insurance Co. of America/MultiFlex Dental

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 8189875000

Thank you for choosing...

Multiflex Dental

MULTIFLEX DENTAL INSURANCE ENROLLMENT FORM

Underwritten by Security Life Insurance Company of America, Minnetonka, MN for NSBA Members • Administered by Merchants Benefit Administration

You must return your enrollment form and 1st Month's Premium and fees or Credit Card Authorization to put your coverage in force!

MEMBER COVERAGE INFORMATION

FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	BIRTH DATE (MM/DD/YYYY)	SEX	MEMBER ID # (for MBA use only)
	/ /	❑ Male ❑ Female	___ ___ ___ – ___ ___ –___ ___ ___ ___

ADDRESS	CITY	STATE	ZIP CODE

BUSINESS PHONE	HOME PHONE	MARITAL STATUS
( ) –	( ) –	❑ Single ❑ Married

CHECK TYPE OF COVERAGE AND PLAN SELECTED

TYPE OF COVERAGE: ❑ Member Only ❑ Member Plus One ❑ Member + Family (Member plus 2 or more)

PLAN SELECTED: ❑ $1,000 ❑ $1,500 ❑ $2,000

REQUESTED EFFECTIVE DATE (MM/01/YYYY) (*Policy issued the first of the month only*)

/ **0 1** /

CALCULATE MONTHLY DUES

MONTHLY PREMIUM Please refer to charts on opposite page to find monthly premium.	$ ________
MONTHLY ADMIN. FEE	$ 5.00
MONTHLY NSBA FEE*	+ $ 1.00
MONTHLY TOTAL DUE	**$** ________

COORDINATION OF BENEFITS

1. DOES SPOUSE HAVE A DENTAL PLAN? ❑ Yes ❑ No

   If answer is "Yes", are dependants enrolled under spouses plan? ❑ Yes ❑ No

2. All DEPENDENT CHILDREN ABOVE AGE 18 ARE FULL TIME STUDENTS? ❑ Yes ❑ No

   If not who? ____________________

DEPENDENT COVERAGE INFORMATION

If more then 4 dependents please attach separate piece of paper with information.

FULL NAME	BIRTH DATE (MM/DD/YYYY)	SEX		MEMBER ID # (for MBA use only)
	/ /	❑ Male ❑ Female	❑ Spouse ❑ Child	___ ___ ___ – ___ ___ –___ ___ ___ ___
	/ /	❑ Male ❑ Female	❑ Spouse ❑ Child	___ ___ ___ – ___ ___ –___ ___ ___ ___
	/ /	❑ Male ❑ Female	❑ Spouse ❑ Child	___ ___ ___ – ___ ___ –___ ___ ___ ___
	/ /	❑ Male ❑ Female	❑ Spouse ❑ Child	___ ___ ___ – ___ ___ –___ ___ ___ ___

PAYMENT OPTIONS

You will receive a monthly invoice regardless of payment method.

I WANT TO PAY BY: ❑ Check or Money Order. Please bill me direct.

Make checks payable to: **SECURITY LIFE INSURANCE CO. OF AMERICA/ MULTIFLEX DENTAL**

CHARGE MY CREDIT CARD: ❑ Visa ❑ MasterCard

DEDUCTION AUTHORIZATION:
I hereby authorize the insurance premiums to be deducted monthly from my credit card and remitted to MULTIFLEX℠. This authority is to remain in effect until I cancel it by written notification to MBA, Inc. at least 30 days in advance of the intended termination date of my coverage. (Any excess premiums which may accrue after termination of my coverage will be refunded to me.)

CREDIT CARD #	EXPIRATION DATE (MM/YYYY)
- - -	/

NAME AS IT APPEARS ON ACCOUNT

ADDRESS ON ACCOUNT (if different from above)

SIGNATURE	DATE (MM/DD/YYYY)
	/ /

PLEASE SIGN AND DATE

By signing on Page 2 of this MULTIFLEX Dental Insurance Form, I hereby apply for coverage under Group Dental Insurance Policy Form GH-1112-38200 issued to the Voluntary Group Trust. I also certify I have read the applicable Fraud Notice below.

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 NOTICES

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 insurer 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.

(Continued on Page 2)

Please turn to Page 2 to complete your application.

	GA NAME & ADDRESS	MGA
Oleg Skurskiy 18375 Ventura Blvd. # 226 Tarzana, CA 91356		

PLEASE SIGN AND DATE (continued)

IMPORTANT FRAUD NOTICES STATE SPECIFIC NOTICES (continued)

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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee: 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.

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.

I hereby enroll in the National Small Business Association. Participation is mandatory. The NSBA monthly membership fee is $1.00 This fee will appear on your monthly invoice.* ***I acknowledge that I have read the statement above and agree to the membership and terms.*

MEMBER SIGNATURE DATE (MM/DD/YYYY)

SPOUSE'S SIGNATURE (if enrolling) DATE (MM/DD/YYYY)

SEND COMPLETED ENROLLMENT FORM TO: MBA • 301 Howard St. Suite #850 • San Francisco, CA 94105

MULTIFLEX AREA NUMBER CHART

HOW TO DETERMINE YOUR MONTHLY PREMIUM

STEP 1 FINDING YOUR AREA NUMBER

1. Find your state on the chart.
2. In the column next to your state, locate the first three numbers of your zip code.
3. The third column contains your area number, which is determined by your state and zip code.
4. Now, go to the Monthly Premium Rate Tables on the form to find your premium.

STATE	ZIP CODE	AREA
Alabama	350-355	3
	359	3
	All Other	1
Alaska	995-996	8
	All Other	6
Arizona	864	2
	856-857	2
	All Other	1
Arkansas	All	1
California	900-905	7
	906-914	6
	915-916	8
	917-918	4
	919-927	6
	930-934	6
	939	6
	943-948	4
	949	6
	956-958	3
	959	4
	961	6
	All Other	5
Colorado	803	4
	808-810	4
	All Other	1
D.C.	All	6
Delaware	All	2
Georgia	300-303	2
	All Other	1
Hawaii	All	3
Idaho	All	1
Illinois	600-605	2
	606-608	3
	All Other	1
Indiana	463-464	2
	473	3
	All Other	1
Iowa	All	1
Kansas	660-662	2
	All Other	1
Kentucky	All	1
Louisiana	707-711	2
	712	3
	All Other	1
Maine	All	1
Michigan	480-483	2
	488-489	3
	490-491	2
	All Other	1
Minnesota	553-558	2
	564	2
	566	2
	All Other	1
Mississippi	390-392	2
	All Other	1

STATE (cont.)	ZIP CODE	AREA
Missouri	640-641	2
	644-649	2
	All Other	1
Montana	590-591	1
	599	2
	All Other	3
Nebraska	All	1
Nevada	890-891	2
	894-895	6
	898	6
	All Other	4
New Mexico	881	2
	882	5
	All Other	1
North Carolina	277	2
	286	3
	287-289	2
	All Other	1
North Dakota	580-581	2
	All Other	1
Ohio	All	1
Oklahoma	740-743	2
	All Other	1
Oregon	977	3
	978	1
	All Other	2
Pennsylvania	170-178	2
	182-187	2
	190-192	3
	All Other	1
South Carolina	All	1
Tennessee	373-374	2
	All Other	1
Texas	751-753	3
	754	4
	756-757	1
	776-777	1
	All Other	2
Utah	All	1
Virginia	201	5
	220-221	5
	222-223	6
	224-225	1
	228-229	2
	230-232	1
	233-237	5
	240-244	2
	All Other	4
Washington	982-984	4
	990-992	3
	993	6
	All Other	5
West Virginia	255-257	4
	262-265	3
	All Other	2
Wisconsin	All	1
Wyoming	All	1

***Plans not available in all states.**
Please contact the plan administrator for complete details.

MULTIFLEX MONTHLY PREMIUM RATE TABLES

HOW TO DETERMINE YOUR MONTHLY PREMIUM

STEP 2 FINDING YOUR PREMIUM

1. Find the Monthly Premium Rate Table that corresponds with the member's age.
2. Find your area number on the Monthly Premium Rate Table.
3. Then, select your coverage type (Member, Member+One, Member + Family).
4. Your Monthly premium is the rate shown under your area number and across from your coverage type.

Rates are effective November 1, 2004 through October 1, 2005

Under age 65

$1,000 Plan Premium Rate for Members

AREA (under 65)	1	2	3	4	5	6	7	8
Member	$26.66	$29.95	$32.91	$35.87	$39.16	$42.13	$46.08	$52.66
Member +One	$50.31	$56.52	$62.12	$67.71	$73.91	$79.51	$86.96	$99.37
Member +Family	$76.47	$85.91	$94.40	$102.89	$112.34	$120.84	$132.17	$151.04

$1,500 Plan Premium Rate for Members

AREA (under 65)	1	2	3	4	5	6	7	8
Member	$29.33	$32.96	$36.20	$39.47	$43.09	$46.35	$50.69	$57.93
Member +One	$55.34	$62.17	$68.32	$74.47	$81.30	$87.45	$95.65	$109.31
Member +Family	$84.11	$94.50	$103.84	$113.19	$123.57	$132.91	$145.39	$166.14

$2,000 Plan Premium Rate for Members

AREA (under 65)	1	2	3	4	5	6	7	8
Member	$30.67	$34.44	$37.85	$41.26	$45.05	$48.46	$52.99	$60.57
Member +One	$57.86	$65.00	$71.42	$77.86	$85.00	$91.42	$100.00	$114.28
Member +Family	$87.93	$98.80	$108.56	$118.33	$129.20	$138.96	$151.99	$173.70

Over age 65

$1,000 Plan Premium Rate for Members

AREA (over 65)	1	2	3	4	5	6	7	8
Member	$29.12	$32.71	$35.95	$39.19	$42.78	$46.02	$50.34	$57.52
Member +One	$49.64	$55.77	$61.29	$66.80	$72.93	$78.44	$85.80	$98.07
Member +Family	$75.45	$84.76	$93.14	$101.53	$110.84	$119.23	$130.39	$149.03

$1,500 Plan Premium Rate for Members

AREA (over 65)	1	2	3	4	5	6	7	8
Member	$32.03	$35.99	$39.55	$43.11	$47.06	$50.62	$55.37	$63.27
Member +One	$54.62	$61.36	$67.41	$73.48	$80.22	$86.28	$94.38	$107.87
Member +Family	$83.00	$93.25	$102.47	$111.67	$121.92	$131.14	$143.44	$163.93

$2,000 Plan Premium Rate for Members

AREA (over 65)	1	2	3	4	5	6	7	8
Member	$33.48	$37.62	$41.34	$45.07	$49.19	$52.93	$57.88	$66.14
Member +One	$57.09	$64.14	$70.48	$76.82	$83.88	$90.21	$98.67	$112.76
Member +Family	$86.77	$97.48	$107.12	$116.77	$127.48	$137.12	$149.96	$171.38

ENROLLMENT QUESTIONS?

Please call your agent or Merchants Benefit Administration at **1-888-538-9333**, Monday—Friday, 8:00AM–5:00PM(Pacific Standard Time).