



A BIG DENTAL PLAN FOR YOUR LOCAL BUSINESS

\$2,000 Annual Benefit w/\$400 Rollover!

Rates zone 4

- \$37.42 Individual
- \$71.08 Plus Spouse
- \$89.54 Plus Child(ren)
- \$132.62 Full Family

**Zone 4 zip codes in 550, 551,
553, 554, 560, 563, 564**

Rates zone 3

- \$33.62 Individual
- \$63.53 Plus Spouse
- \$79.67 Plus Child(ren)
- \$117.95 Full Family

**Zone 3 zip codes in 555, 556,
557, 558, 559, 561, 562, 565,
566, 567**

**COMPLETE THE INCLUDED APPLICATIONS AND EMAIL THEM TO
DENTAL@SWARTZENDRUBERAGENCY.COM**

Additional Options Include

dental - disability - life - supplemental health - cancer
benefits education & enrollment professionals

Office 763-862-2400
smallgroupdental.com



Find Your Dentist @ Coloniallifedental.com

Dental Insurance

Plan 4 – \$2,000, 100% | 80% | 50%

Our Most Popular Plan Level!



For more information,
talk with your
benefits counselor.

ColonialLife.com

Dental insurance from Colonial Life can help preserve your smile with easy-to-use coverage that promotes overall wellness.

Benefits can help with a variety of dental costs, from routine cleanings to more advanced procedures. Coverage is available for you, your spouse and dependent children.

Plan details

The benefit year maximum for this plan is \$2,000.

Class A, B and C services apply toward the benefit year maximum.

This plan has a deductible of \$50 per person.

Families only pay the deductible for a maximum of three people.

Applies only to class B and C services.

The co-insurance for this plan is:

CLASS	TYPE OF SERVICE	INSURANCE PAYS
Class A	Preventive services	100%
Class B	Basic services	80%
Class C	Major services	50%

Network

Our national dental network offers more than 323,000 access points.¹ Members may choose any dentist but may receive additional savings by choosing an in-network dentist. Plus, services not covered by this plan may also still be eligible for in-network savings.² Out-of-network benefits are paid at the network negotiated rate.³

To locate a participating dentist, access the provider search at ColonialLife.com.

See reverse for covered procedures and waiting periods.

Covered procedures and waiting periods

Preventive services (Class A): No waiting period

- Routine exams and cleanings (twice every 12 months)
 - One additional cleaning per 12 months if member is in second or third trimester of pregnancy⁴
- X-rays
 - Bitewing X-rays (up to four films; once every 12 months)
 - Full mouth/panoramic x-rays (once every five years)
- Children's services (up to age 14)
 - Fluoride treatment (once every 12 months)
 - Sealants (once every 36 months)
 - Space maintainers (up to age 14; once every 24 months)
- Adjunctive pre-diagnostic oral cancer screening (for age 40 or older; once every 12 months)

Basic services (Class B): No waiting period

- Simple restorative services (fillings)
- Simple extractions
- Emergency treatment
- Repair of crown, denture or bridge

Major services (Class C): 12-month waiting period

- Oral surgery (extractions and impacted teeth)
- Anesthesia (subject to review; covered with complex oral surgery)
- Periodontics (gum treatments)
- Endodontics (root canals)
- Inlays and onlays
- Crowns
- Bridges
- Dentures
- Endosteal implants (in lieu of an approved three-unit bridge)

1 Internal data (2017). Access points are sites where network dentists see patients. Some dentists may be available at more than one access point.

2 Not an insured benefit.

3 If you visit an out-of-network dentist, you may be billed for remaining amounts over the benefit amount paid, up to the billed charge.

4 Member may have one additional periodontal maintenance in lieu of an additional cleaning. Periodontal maintenance is a major service and subject to a 12-month waiting period.

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. See the actual policy or your Colonial Life benefits counselor for specific provisions and details of availability.

Individual Dental PPO Insurance

Rollover Benefit – \$2,000 Annual Maximum Plan



For more information,
talk with your
benefits counselor.

ColonialLife.com

Earn extra benefits just by taking care of your teeth.

How it works

Each benefit year, a member must have:

- One cleaning
- One regular exam
- Total dental claims paid during the year below the threshold limit

If all three criteria are met, a portion of the annual maximum will roll over to the next year.

BASE PLAN ANNUAL MAXIMUM	THRESHOLD LIMIT ¹	ROLLOVER AMOUNT ¹	ROLLOVER ACCOUNT MAXIMUM	TOTAL POTENTIAL ANNUAL MAXIMUM
\$2,000	\$800	\$400	\$1,600	\$3,600

¹ Per benefit year

Additional information

- Each covered family member receives his or her own rollover benefit.
- A member must be covered for one benefit year to use his or her rollover benefit.
- The rollover benefit cannot be used toward orthodontia, if offered.
- The rollover account balance will be eliminated if the member has a break in coverage for any reason.

See reverse for rollover example.

\$2,000 rollover example

First qualifying year

A member has one cleaning, one regular exam and a total of \$300 in paid claims, which is less than the threshold limit. Therefore, the member earns a \$400 rollover benefit that is added to the rollover account.

Benefit in year two

Annual maximum		Rollover account		Total annual maximum with rollover
\$2,000	+	\$400	=	\$2,400

The member has one cleaning, one regular exam and a total of \$300 in paid claims, which is less than the threshold limit. Therefore, the member earns another \$400 rollover benefit that is added to the rollover account.

Benefit in year three

Annual maximum		Rollover account		Total annual maximum with rollover
\$2,000	+	\$800	=	\$2,800

The member has one cleaning, one regular exam and a total of \$2,200 in paid claims, which is over the threshold limit. He or she will not earn a rollover benefit, but is able to use the benefit earned in previous years to help pay the \$2,200 in claims. Also, because the entire \$800 rollover benefit is not used, \$600 will remain in the rollover account.

Benefit in year four

Annual maximum		Rollover account		Total annual maximum with rollover
\$2,000	+	\$600	=	\$2,600

The member has \$2,600 available to use in this year because of the \$2,000 regular annual maximum plus \$600 in remaining rollover benefit.



ColonialLife.com

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form IDN8000 or contact your Colonial Life benefits counselor.

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Individual Dental PPO Insurance

Vision Rider



For more information,
talk with your
benefits counselor.

ColonialLife.com

Dental insurance offers an optional vision rider to help pay for eye exams and materials, such as glasses and contact lenses. This coverage can help you maintain healthy vision and overall wellness, as well as provide valuable financial protection for you, your spouse and dependent children.

Vision benefits	IN-NETWORK	OUT-OF-NETWORK ALLOWANCE
CO-PAYS		
Exam (once per 12 months)	\$10	Up to \$35
Materials	\$25	See below
STANDARD PLASTIC LENSES¹ (once per 12 months)		
Single vision	Covered by co-pay	Up to \$25
Bifocal	Covered by co-pay	Up to \$40
Trifocal	Covered by co-pay	Up to \$50
Lenticular	\$80 allowance	Up to \$50
Progressive	\$70 allowance	Up to \$40
Polycarbonate lenses (for children to age 19)	Covered by co-pay	N/A
FRAMES¹ (once per 12 months)		
Choose any frame available at provider locations	\$120 allowance	Up to \$50
CONTACT LENSES² (once per 12 months) (Includes fit, follow-up and materials) In lieu of eyeglass lenses and frames		
Elective	Up to \$120 allowance	Up to \$100 allowance
Medically necessary	Up to \$210 allowance	Up to \$210 allowance

Freedom of choice

You'll have access to a national vision network that includes independent optometrists, ophthalmologists and retail stores including Walmart, Sam's Club Optical, Costco,³ Pearle Vision and Target. You can search for providers at ColonialLifeVision.com.

Additional vision benefit advantages

- Eye exams and materials (frames, lenses) can be purchased from different locations and providers. For example, you could have an eye exam with your favorite eye care professional and order contacts online.
- Check the network for Value Added and Service Plus providers. They can provide special discounts for extra purchases of lenses and coatings, frames, contact lenses and other products.



Special discounts on material purchases⁴

Providers identified as Value Added or Service Plus in our online provider directory offer the following additional values for our members on vision material purchases.

We encourage you to contact your selected provider prior to visiting their location to confirm their continued participation. Not all providers, such as Walmart, Sam's Club and Costco Optical,³ choose to participate in these special discounts.

Value Added providers

DISCOUNTS FOR FIRST PAIR OF GLASSES

Lens options (add-ons for insured purchases):

- UV coating...\$15
- Solid tinting/gradient tinting...\$15
- Standard scratch resistance coating...\$15
- Standard anti-reflective coating...\$45
- Premium anti-reflective coating...\$70
- Ultra anti-reflective coating...20% discount
- Polarized...\$75
- Transition...\$75
- Progressive lenses:
 - Standard...\$110
 - Premium...\$170
 - Ultra...member receives a 20% discount
- Standard polycarbonate ...\$40
- High index (single vision)
 - 1.56-1.60...\$60
 - 1.66+...20% discount
- High index (multi-focal)
 - 1.56-1.60...\$75
 - 1.66+...20% discount

PURCHASE A SECOND PAIR OF GLASSES AND RECEIVE PREFERRED PRICING

Lenses:

- Single vision plastic lenses...\$40
- Bifocal plastic lenses...\$60
- Trifocal lenses...\$70
- Progressive lenses (standard)...\$110
- Progressive lenses (premium and ultra)...20% discount

DISCOUNTS ON FRAMES, CONTACT LENSES AND OTHER PRODUCTS

- **Frames** – Up to 35% discount
- **Contact Lenses** – 5-15% discount, depending on type
- **Other products** – 20% discount on non-prescription sunglasses and other ancillary products/solutions⁵

Service Plus providers

RECEIVE UP TO A 20% DISCOUNT FOR THE FOLLOWING ADD-ONS TO INSURED PURCHASES:

- UV coating
- Solid tinting/gradient tinting
- Standard scratch resistance coating
- Standard anti-reflective coating
- Premium anti-reflective coating
- Transition
- Standard polycarbonate

ColonialLife.com

¹ Eyeglass lenses and frames are paid in lieu of the contact lenses benefit.

² The contact lenses benefit is paid in lieu of eyeglass lenses and frames. Contact lenses consist of three components: materials, exams and fittings. Coverage is for materials and the exam, up to the contact lenses allowance. Fittings may be covered but only up to the amount of any unused contact lenses allowance – after materials.

³ Optometrists at Costco Optical outlets are independent of Costco and may not be in network. To verify that your vision exam will be fully covered after co-pay, confirm that your doctor is an in-network provider. Special payment and reimbursement terms apply for material purchases at Costco. Additional discounts are not applicable.

⁴ Not a covered benefit. These schedules are subject to change without notice. Added value discounts may not be available in all geographical areas and vary by network. Many providers are not able to offer discounts on "Prestige" frames. Special lens packages that combine numerous lens enhancements at value price points are not covered by these added value programs. Cannot be combined with any other promotions or discounts.

⁵ Some retail chains sell sunglasses in departments outside of their optical shops where discounts do not apply.

The policy or its provisions may vary or be unavailable in some states. The policy had exclusions and limitations, which may affect any benefits payable. See the actual policy or your Colonial Life benefits counselor for specific provisions and details of availability.

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Our Monthly Dental Rates



Individual Dental PPO MN

Applicable to policy form Individual Dental PPO(IDN8000)

- Includes a \$400 Annual Rollover Benefit!

Zip Codes: 550, 551, 553, 554, 560, 563, 564

COVERAGE LEVEL	ISSUE AGE	INDIVIDUAL	INDIVIDUAL AND SPOUSE	INDIVIDUAL AND CHILDREN	INDIVIDUAL AND FAMILY
Plan 4 - 100/80/50, \$2,000 MAC	17-74	\$37.42	\$71.08	\$89.54	\$132.62

Individual Dental PPO MN

Applicable to policy form Individual Dental PPO(IDN8000)

- Includes a \$400 Annual Rollover Benefit!

Zip Codes: 555, 556, 557, 558, 559, 561, 562, 565, 566, 567

COVERAGE LEVEL	ISSUE AGE	INDIVIDUAL	INDIVIDUAL AND SPOUSE	INDIVIDUAL AND CHILDREN	INDIVIDUAL AND FAMILY
Plan 4 - 100/80/50, \$2,000 MAC	17-74	\$33.62	\$63.53	\$79.67	\$117.95

Add Vision to Your Dental Coverage!

Vision - All Plans	
Named Insured	\$6.47
Named Insured and Spouse	\$12.80
One-Parent Family	\$13.48
Two-Parent Family	\$21.11

Important Notice

Insurance coverage has exclusions and limitations that may affect benefits payable. For a complete description of benefits, limitations and exclusions, please refer to an outline of coverage, sample policy/certificate, proposal description or see your Colonial Life benefits counselor. Coverage type, benefits and rates vary by state. Coverage may not be available in all states. Rates provided are illustrative and your actual premium may be different depending on your particular situation and plan choices.

Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.

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Producer Contact: 1.800.43VOICE, Option 2, 2

Fax Forms to 1.800.543.8573 or email to newaccountservicecenter@coloniallife.com

Account Information

Account name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

If this account is associated with another Colonial Life or one of its affiliates' accounts, please provide the name and BCN of the account or master group number: _____

Account billing address (if different from above address): _____

Contact person for billing and service: _____
First Name Middle Initial Last Name Title

E-mail address: _____

Are there locations that will be written in NY? ☐ Yes ☐ No

Number of benefit-eligible employees: _____ Federal Tax ID: _____

Exact nature of business: _____

Will a third party administer, reconcile and/or remit the premium deductions? ☐ Yes ☐ No

If yes, is the third party a: ☐ Payroll Company ☐ Professional Employer Organization ☐ Other _____

Please indicate name, address, phone number and contact person _____

***A Premium Services and Administration Agreement may be needed.**

Will any deductions be made pretax? ☐ Yes ☐ No If yes, include Flex Plan Supplemental Form.

Will the employer be contributing any premium toward the Colonial Life benefits? ☐ Yes ☐ No

If applicable to your state and company position, as allowed by law, please signify if domestic partner or civil union relationships are recognized by your company? ☐ Yes ☐ No

IMPORTANT COMPENSATION DISCLOSURE INFORMATION

Colonial Life is committed to helping working Americans and their families minimize personal financial risk with a comprehensive offering of voluntary benefits through the workplace. Colonial Life compensates producers to facilitate the sale and delivery of these valuable benefits. This compensation might include commissions as well as various incentives and awards.

We support the full disclosure of compensation programs for our products, and your insurance advisor can provide you with complete information about these programs. You may also learn additional information about our compensation programs by contacting our Plan Administrator Service Center at 1.800.256.7004.

Initials of Authorized Officer

Is employer/account paying a fee to an insurance advisor for this placement of Colonial Life insurance? ☐ Yes ☐ No _____

If yes, list advisor(s) names _____

A completed Compensation Consent and Disclosure Form 62291 is required for each insurance advisor receiving a fee.

If fee is paid in the future, it is the employer's responsibility to notify Colonial Life of the change.

The employer account (and/or its assigns) agrees to forward promptly all insurance premiums payroll deducted from its employees to Colonial Life & Accident Insurance Company (hereafter Colonial Life) for payment of employee insurance coverage and to notify Colonial Life promptly of the names of any employees to cease deductions because of termination from employment or otherwise. If the employer fails to notify Colonial Life that an individual's employment has terminated, that an individual has otherwise ceased deductions or where there is some other misunderstanding between the employer and employee concerning the payroll deductions, Colonial Life agrees to reimburse the employer up to one (1) month's premium in the event of loss by the employer as long as a claim has not been paid. Refund of premiums on flexible benefit plan accounts will be made payable to the employer. The issuance of any coverage paid for by payroll deduction pursuant to this agreement does not relieve the employer of the requirements of Workers' Compensation Laws of their state.

Signed at: _____ this _____ day of _____
City and State

Print Name and Title of Authorized Officer

Signature of Authorized Officer

Submitted by _____ Producer # _____ Producer Telephone Number _____

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
PO BOX 1365, COLUMBIA, SC 29202

DENTAL INSURANCE APPLICATION FORM

<input type="checkbox"/> New Coverage <input type="checkbox"/> Reinstatement	<input type="checkbox"/> Upgrade <input type="checkbox"/> Downgrade	<input type="checkbox"/> Dependent Addition <input type="checkbox"/> Rider Addition	Existing Policy No. _____
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EMPLOYEE SECTION					
Proposed Insured Name (First, MI, Last)			Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street		City	State	Zip Code	
Email Address				Home Phone No. Business Phone No.	
Date Employed	Hrs. Worked/Wk	Section/Dept. No.	Job Title		Employee ID/Payroll No.
Employer Name			Employer Address (Street-City-State-Zip)		

SPOUSE/DEPENDENT SECTION (complete if applying for spouse and/or dependent coverage)				
Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			

ELIGIBILITY SECTION	
1. Are you actively working? If "No" you are not eligible for any coverage.	Yes <input type="checkbox"/> No <input type="checkbox"/>

REPLACEMENT SECTION	
2a. Will any dental insurance with this or any other company be replaced or changed if the coverage applied for is issued? If yes, complete required replacement form if applicable in your state and complete 2b. 2b. If replacing existing coverage, please indicate if existing coverage is Colonial Life & Accident Dental coverage or another carrier's Dental coverage by checking the appropriate box. <input type="checkbox"/> Colonial Life & Accident Insurance Company <input type="checkbox"/> Other	Yes <input type="checkbox"/> No <input type="checkbox"/>

PLAN SECTION					
Type of Coverage	Type of Change (N) New (T) Transfer (R) Rider Addition	Policy Plan Code	Rider Plan Code	Tax Status (P) pre-tax (A) after tax	Monthly Premium
<input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Individual & Children <input type="checkbox"/> Individual & Family				P <input type="checkbox"/> A <input type="checkbox"/>	

OTHER SECTION	
3. Do you have any existing dental coverage that will remain in force? If yes, please provide company name.	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Are you Medicare eligible?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Has the Important Notice to Persons on Medicare and the Guide to Health Insurance for People with Medicare been provided?	Yes <input type="checkbox"/> No <input type="checkbox"/>

AGREEMENT SECTION

It has been explained and I understand that any coverage approved may be subject to waiting periods, exclusions and limitations as described in the policy.

I understand that this application will not be binding upon Colonial Life until both: 1) the policy is issued; and 2) the first premium is paid. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. I understand that any untrue statement or material misrepresentation may result in claim denial or rescission of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all premiums paid. I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I also understand that my payroll deduction amount will change if my coverage or premium changes.

Any person who knowingly and with the 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the coverage indicated, I hereby request cancellation of my Colonial Life Policy Number(s) _____. Transfer or cancellation of the base plan will also mean cancellation of all attached riders. If for any reason the coverage applied for above is not issued, this request for cancellation shall be null and void.

This policy provides dental and/or vision benefits only. Review your policy and any applicable riders carefully.

Signed at: City _____ State _____ Zip Code _____ Date _____
mm/dd/yyyy

(x) _____
Signature of Proposed Insured (if applicable)

AGENT SECTION

Agent's Name (If Present): _____
(please print)

Do you have knowledge or reason to believe that the Proposed Insured is intending to replace any existing dental insurance? Yes ☐ No ☐

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to waiting periods and limitations, if applicable. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I have not made, nor agreed to make, any rebate of premium for insurance. I further certify that I am a licensed agent in the state where this application is being taken.

Date _____ (x) _____ License No. _____ Code No. _____
mm/dd/yyyy Signature of Licensed Agent