

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: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction or credit card), quarterly (every three months) or annually (once a year). Send a voided check for your 1st months premium.

Step 3

SEND THE COMPLETED APPLICATION TO:

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:

Thank you for choosing...

 **DELTA DENTAL**



Vision for Everyone

Administered by: **SPECTERA**[®]
A UnitedHealth Group Company

Plan Features

- No deductibles
- No waiting periods
- Your choice of network providers
- One pair of standard frames each 24 months
- A vision examination annually
- One pair of single vision or standard lined multi-focal lenses (or)
- Contact lenses each 12 months
- Benefits provided In-Network only
- Laser eye surgery benefits through Laser Vision Network of America

Benefit Co-Payments

| | |
|--------------------|---------|
| Examinations | \$15.00 |
| Materials | \$25.00 |

For more information
email marketing@morganwhite.com
or call 1-800-800-1397

In-Network Benefits

Exam: A complete vision examination by a participating optometrist or ophthalmologist every 12 months with a \$15 co-pay each year.

Lenses: If prescribed, a pair of single vision or standard lined multi-focal lenses every 12 months with a \$25 co-pay each year.

Contact Lenses: After a \$25 co-pay each year, Spectera Inc's contact lense benefit covers in full the fitting / evaluation fees, contacts (disposable contacts / up to 4 boxes, depending on the prescription and plan selected), and up to two follow up visits. A \$105 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of Spectera, Inc.'s covered-in-full contacts (materials co-pay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection. Any amount over the allowance is the patient's responsibility.

Frames: Your choice from a wide selection of fashionable frames will be covered-in-full every 24 months. The materials co-pay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses. If you select a frame from outside the covered selection, you will be given a minimum \$130 frame allowance for frames purchased at retail chain providers.

Patient Options: Should you select items not covered by the program, such as: progressive lenses, tints, coatings, etc., there will be an additional charge. These charges, however, are below usual retail costs. (Standard Scratch coating is covered in full at no cost to the insured).

Monthly Premium Individual Rates

Two Year Rate Guarantee. Available to Individuals by: Monthly bank draft or credit card

| Standard Premium Rates | |
|------------------------|---------|
| Member | \$10.50 |
| Member & One | \$16.50 |
| Member & Family | \$23.15 |

Rates include a \$2 billing fee.

| Available States |
|--|
| AR, AL, AZ, CA, CO, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WY, WV |

In-Network Provider Access

Call Spectera at 1-800-839-3242 or go online at www.spectera.com

SPECTERA * Vision Enrollment Form

| | | | | | | |
|--|--------------------------------|---------|-----------|--|--|--|
| Social Security No. - - | Primary Enrollee: Last Name | First | Initial | Birthdate / / | Sex <input type="checkbox"/> M <input type="checkbox"/> F | MODE OF PAYMENT <input type="checkbox"/> Annually or <input type="checkbox"/> Monthly <input type="checkbox"/> Bankdraft or <input type="checkbox"/> Credit Card BANKDRAFT: This is authorization for Morgan-White Administrators, Inc., on behalf of Spectera to draft payments from my checking account for payment of my insurance premiums. Drafts will occur between the 1st - 5th of each month for the following month's premium. Enclosed is a check for the first month's premium plus a blank voided check on the bank on which drafts are to be drawn. OR <input type="checkbox"/> Charge Premiums to: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard Credit Card #: _____ Exp. Date ____/____/____ Signature: _____ |
| Home Phone () | Street | | | | | |
| | City | State | Zip | | | |
| LIST ALL DEPENDENTS TO BE COVERED BELOW | | | | | | |
| Last Name (if different) | First Name | Initial | Birthdate | Sex <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 1. Spouse | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 2. Dependents | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 3. | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 4. | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 5. | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 6. | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |

If dependent children (between the ages of 19 and 24) are not full-time students they are not eligible to enroll.

"I understand and agree that (1) the insurance shall not take effect unless the application has been accepted and approved by the Company and until the Effective Date of the Certificate and (2) the agent does not have the authority to make or alter any contract or waive any of the Company's other rights or requirements." California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Applicant's Signature _____ **Date** _____

DDO3VOLU AGENT NAME (if applicable): JIM BARRICKS
AGENT # (Your state license #): CA# 0383850 Phone: (310) 827-7286
Forward enrollment form to: MorganWhiteGroup - P.O. Box 14067 Jackson, MS 39236