



AFA Veteran Benefits Association
1501 Lee Hwy., Arlington, VA 22209
1-800-291-8480

www.afavba.org * services@afavba.org

AFAVBA Dental Plan Benefits

Get the benefits with savings you need, the flexibility you want and service you can trust.

Benefit Summary

| Plan Option 1 Benefit Highlights: | | | Plan Option 2 Benefit Highlights: | | |
|--|------------------------|------------------------|---|------------------------|------------------------|
| Comprehensive Plan Description | | | Basic Plan Description | | |
| Your AFAVBA Plan Pays | | | Your AFAVBA Plan Pays | | |
| Coverage Type | PDP In-Network: | Out-of-Network: | Coverage Type | PDP In-Network: | Out-of-Network: |
| Type A – cleanings, oral examinations | 100% of PDP Fee* | 100% of PDP Fee* | Type A – cleanings, oral examinations | 100% of PDP Fee* | 100% of PDP Fee* |
| Type B – fillings | 80% of PDP Fee* | 80% of PDP Fee* | Type B – fillings | 60% of PDP Fee* | 60% of PDP Fee* |
| Type C – bridges and dentures | 50% of PDP Fee* | 50% of PDP Fee* | | | |
| Type D – orthodontia | 50% of PDP Fee* | 50% of PDP Fee* | | | |
| Deductible*** | In-Network | Out-of-Network | Deductible*** | In-Network | Out-of-Network |
| Individual | \$50 | \$50 | Individual | \$75 | \$75 |
| Family | \$150 | \$150 | Family | \$225 | \$225 |
| Annual Maximum Benefit: | In-Network | Out-of-Network | Annual Maximum Benefit: | In-Network | Out-of-Network |
| Per Person | \$2,000 | \$2,000 | Per Person | \$1,000 | \$1,000 |
| Orthodontia Lifetime Maximum: | In-Network | Out-of-Network | ORTHODONTIA NOT AVAILABLE | | |
| Per Person | \$1,000 | \$1,000 | | | |
| Waiting Period: 6 month Waiting Period for all Type C Services. | | | | | |
| PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefit maximums. Applies only to type B & C Services. | | | PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximums. Applies only to type B Services. | | |

The service categories shown above represent an overview of your Plan of Benefits but are not a complete description of the Plan. An insurance certificate describing all benefits and limitations will be made available following your plan's effective date, and will govern if any discrepancies exist between this overview and the certificate of insurance and group insurance policy.

Monthly Rates: The following monthly rates are effective through December 31, 2012.

Plan 1 – Comprehensive Plan

| Eligibility Options | Region 1 | Region 2 | Region 3 | Region 4 |
|---------------------|-----------|----------|----------|----------|
| Member Only | \$ 52.92 | \$ 58.14 | \$ 66.58 | \$ 73.14 |
| Member + One | \$ 104.42 | \$114.94 | \$131.97 | \$145.74 |
| Member + Family | \$151.43 | \$166.79 | \$191.64 | \$211.77 |

Plan 2 – Basic Plan

| Eligibility Options | Region 1 | Region 2 | Region 3 | Region 4 |
|---------------------|----------|----------|----------|----------|
| Member Only | \$23.78 | \$26.01 | \$29.59 | \$32.49 |
| Member + One | \$45.87 | \$50.35 | \$57.62 | \$63.49 |
| Member + Family | \$67.38 | \$74.09 | \$84.93 | \$93.72 |

An example of savings when you visit a participating PDP dentist:

This hypothetical example* shows how receiving services from a PDP dentist can save you money.

| Comprehensive Plan | | Basic Plan | |
|--|---|--|---|
| Your Dentist says you need a Crown, a Type C service: | | Your Dentist says you need a Filling , a Type B service: | |
| PDP Fee: \$375.00 | | PDP Fee: \$42.00 | |
| R&C Fee: \$500.00 | | R&C Fee: 95.00 | |
| Dentist’s Usual Fee: \$600.00 | | Dentist’s Usual Fee: \$113.00 | |
| *Please note: This example assumes that your annual deductible has been met. | | *Please note: This example assumes that your annual deductible has been met. | |
| IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK |
| When you receive care from a participating PDP dentist: | When you receive care from a non-participating dentist: | When you receive care from a participating PDP dentist: | When you receive care from a non-participating dentist: |
| Dentist's Usual Fee is: \$600.00 | Dentist's Usual Fee is: \$600.00 | Dentist's Usual Fee is: \$113.00 | Dentist's Usual Fee is: \$113.00 |
| The PDP Fee is: \$375.00 | The R&C Fee is: \$500.00 | The PDP Fee is: \$ 42.00 | The R&C Fee is: \$95 .00 |
| Your Plan Pays: | Your Plan Pays: | Your Plan Pays: | Your Plan Pays: |
| 50% X \$375 PDP Fee -\$187.50 | 50% X \$500 R&C Fee -\$250.00 | 60% X \$42 PDP Fee -\$ 25.20 | 60% X \$95 R&C Fee -\$ 57.00 |
| Your Out-of-Pocket Cost: \$187.50 | Your Out-of-Pocket Cost: \$350.00 | Your Out-of-Pocket Cost: \$ 16.80 | Your Out-of-Pocket Cost: \$ 56.00 |

**In this example, you save \$162..50
(\$350.00 minus \$187.50)...
by using a participating PDP dentist.**

**In this example, you save \$39.20
(\$56.00 minus \$16.80)...
by using a participating PDP dentist.**

List of Primary Covered Services & Limitations

| Primary Covered Services Plan Option 1: Comprehensive Plan | | Primary Covered Services Plan Option 2: Basic Plan | |
|---|---|---|--|
| Type A - Preventive | <u>How Many/How Often:</u> | Type A - Preventive | <u>How Many/How Often:</u> |
| Prophylaxis (cleanings) | <ul style="list-style-type: none"> Two per calendar year, separated by a six-month period. | Prophylaxis (cleanings) | <ul style="list-style-type: none"> Two per calendar year, separated by a six-month period. |
| Oral Examinations | <ul style="list-style-type: none"> Two exams per calendar year, separated by a six-month period. | Oral Examinations | <ul style="list-style-type: none"> Two exams per calendar year, separated by a six-month period. |
| Topical Fluoride Applications | <ul style="list-style-type: none"> One fluoride treatment per calendar year for dependent children up to 19th birthday. | Topical Fluoride Applications | <ul style="list-style-type: none"> One fluoride treatment per calendar year for dependent children up to 19th birthday. |
| X-rays | <ul style="list-style-type: none"> Bitewing X-rays: one set per calendar year for adults & children. | X-rays | <ul style="list-style-type: none"> Bitewing X-rays: one set per calendar year for adults & children. |
| Sealants | <ul style="list-style-type: none"> One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday. | Sealants | <ul style="list-style-type: none"> One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday. |
| Type B - Basic Restorative | <u>How Many/How Often:</u> | Type B - Basic Restorative | <u>How Many/How Often:</u> |
| Fillings | | Fillings | |
| Labs & other tests | | Labs & other tests | |
| Pulp Capping/Pulpal Therapy | | Pulp Capping/Pulpal Therapy | |
| Palliative Care | | Palliative Care | |
| Periodontics | <ul style="list-style-type: none"> Periodontal maintenance where periodontal treatment (including scaling, root planning, and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to 4 times in any year less the number of teeth cleanings received during such 12-month period. | Periodontics | <ul style="list-style-type: none"> Periodontal maintenance where periodontal treatment (including scaling, root planning, and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to 4 times in any year less the number of teeth cleanings received during such 12-month period. |
| Space Maintainers | <ul style="list-style-type: none"> Limitation of one space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 19. | Space Maintainers | <ul style="list-style-type: none"> Limitation of one space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 19. |
| X-rays | <ul style="list-style-type: none"> Full mouth X-rays: one per 60 months. | X-rays | <ul style="list-style-type: none"> Full mouth and panoramic x-rays: once per 60 months. |
| Periapicals and other x-rays | | Periapicals and other x-rays | |
| Type C - Major Restorative* | <u>How Many/How Often:</u> | Type C - Major Restorative | NOT COVERED |
| Simple Extractions | | | |
| Crown, Denture and Bridge Repair | <ul style="list-style-type: none"> Initial installation of fixed bridgework Initial installation of partial or full removable dentures Adjustment of dentures (minimum is 6 months after initial installation) Initial installation of crowns, inlays and onlays (cast restorations): On once in 60 consecutive months. | | |
| Implants | <ul style="list-style-type: none"> Initial installation of implants: once in 60 consecutive months. Maintenance or repair of implant services: once in 12 consecutive months. | | |
| Bridges and Dentures | <ul style="list-style-type: none"> Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. Dentures and bridgework replacement: one every 10 years. Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed (minimum is 6 months after initial installation). Replacement: once every 5 years. | | |
| Crowns/Inlays/Onlays | <ul style="list-style-type: none"> Replacement: once every 5 years. | | |
| Endodontics | <ul style="list-style-type: none"> Root canal treatment limited to once per tooth per 24 months. | | |
| General Anesthesia & IV Sedation | <ul style="list-style-type: none"> When dentally necessary in connection with oral surgery, extractions or other covered dental services. | | |
| Oral Surgery & Surgical Extractions | | | |
| Periodontics | <ul style="list-style-type: none"> Periodontal scaling and root planning once per quadrant, every 24 months. Periodontal surgery including gingivectomy or gingivoplasty, gingival curettage, osseous surgery, bone replacement graft and guided tissue regeneration once per quadrant every 36 months. Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year. | | |
| Consultations | <ul style="list-style-type: none"> Limited to twice in 12 consecutive months. | | |
| Rebases/Relines | <ul style="list-style-type: none"> Relines and rebases to dentures are limited to one per 36 months (minimum is 6 months after initial installation) | | |
| Repairs | | | |
| Harmful Habit Appliance | | | |
| Type D - Orthodontia | <u>How Many/How Often:</u> | Type D - Orthodontia | NOT COVERED |
| | <ul style="list-style-type: none"> All dental procedures performed in connection with Orthodontic treatment are payable as Orthodontia. Initial payment due upon installation of the Orthodontic appliance; repetitive payments for the Orthodontic adjustments will be made quarterly at the end of the quarter based on the Orthodontic Lifetime Maximum. Orthodontic benefits end at cancellation of coverage. | | |
| Orthodontic Diagnostics | | | |

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan. A group insurance policy including a certificate of insurance will be made available following your plan's effective date, and will govern if any discrepancies exist between this overview and the actual group insurance policy. If non-insured, the summary plan description will be made available following your plan's effective date and will govern if any discrepancies exist between this overview and the actual group insurance policy.

*There is a 6 months waiting period for Type C services.

Common Questions...Important Answers

Q. What is a participating PDP dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in-full for services provided to plan participants. PDP fees typically range from 10-35%[‡] below the average fees charged by dentists in your area for the same or substantially similar services.

Q. How do I find a participating PDP dentist?

A. There are more than 128,000 participating PDP dentist locations nationwide, including more than 31,023 specialist locations. You can get a list of these participating PDP dentists online at www.metlife.com/dental, select dental, select PPO and enter zip code or call 1-800-291-8480 to have a list faxed or mailed to you.

Q. What services are covered by the Preferred Dentist Program (PDP)?

A. The services covered by the MetLife PDP are those defined under your group dental benefits plan. Please review the enclosed plan benefits to learn more.

Q. Does the Preferred Dentist Program (PDP) offer any discounts on non-covered services?

A. Yes. The PDP in-network discounts do extend even to non-covered services, such as cosmetic dentistry or orthodontia, providing plan participants with savings on these non-covered services as well.

Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee and your plan's payment. Please note: plan designs may vary, so you should always refer to your company's specific plan to help determine actual out-of-network benefits. As always, plan deductibles must be met.

Q. Can my dentist apply for PDP participation?

A. Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply for membership, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. Website and phone number are designed for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your claims for you which helps to reduce your paperwork. If you need a claim form, you can find one online at www.metlife.com/dental and click on "Download Claim Forms" from the homepage. You may also call 800-942-0854 to have a form sent to you – you can call 24 hours, 7 days a week, to utilize MetLife's automated voice response system.

Q. When will my coverage be effective?

A. The coverage will be effective first of the month following receipt of completed application and premium payment.

[‡] Based on internal analysis by MetLife

Exclusions – Plan 1 (Comprehensive Plan)

This plan does not cover the following services, treatments and supplies:

- Temporomandibular joint disorder (TMJ)
- Services which are not Dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature
- Services for which You would not be required to pay in the absence of Dental Insurance
- Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person
- Services not performed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for: scaling and polishing of teeth; or fluoride treatments
- Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child.
- Services or appliances which restore or alter occlusion or vertical dimension
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease
- Restorations or appliances used for the purpose of periodontal splinting
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss
- Decoration or inscription of any tooth, device, appliance, crown, or other dental work
- Missed appointments
- Services covered under any workers' compensation or occupational disease law
- Services covered under any employer liability law
- Services for which the member or the person receiving such services is not required to pay
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder
- Temporary or provisional restorations or appliances
- Prescription drugs
- The following when charged by the Dentist on a separate basis: claim form completion; infection control such as gloves, mask, and sterilization or supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental service arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food
- Services for which the submitted documentation indicates a poor prognosis
- Caries susceptibility tests
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders
- Initial installation of a Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth
- Precision attachments associated with fixed and removable prostheses
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it
- Duplicate prosthetic devices or appliances
- Replacement of a lost or stolen appliance or crown, inlay/onlay, or Denture

Exclusions - Plan 2 (Basic Plan)

This plan does not cover the following services, treatments and supplies:

- Type C (Major) & Type D (Orthodontia)
- Temporomandibular joint disorder (TMJ)
- Harmful habits appliance
- Services which are not Dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature
- Services for which You would not be required to pay in the absence of Dental Insurance
- Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person
- Services not performed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for: scaling and polishing of teeth; or fluoride treatments
- Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child.
- Services or appliances which restore or alter occlusion or vertical dimension
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease
- Restorations or appliances used for the purpose of periodontal splinting
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss
- Decoration or inscription of any tooth, device, appliance, crown, or other dental work
- Missed appointments
- Services covered under any workers' compensation or occupational disease law
- Services covered under any employer liability law
- Services for which the member or the person receiving such services is not required to pay
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder
- Temporary or provisional restorations or appliances
- Prescription drugs
- The following when charged by the Dentist on a separate basis: claim form completion; infection control such as gloves, mask, and sterilization or supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental service arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food
- Services for which the submitted documentation indicates a poor prognosis
- Caries susceptibility tests
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 ASSN) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy

Like most group health insurance policies, MetLife group policies contain certain exclusions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife for complete details.

For insured plans: Like most group health insurance policies, MetLife group policies contain certain exclusions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife for complete details.



**Air Force Association
Veteran Benefits Association
Region Locator**

How to Use This Chart:

To determine the appropriate premium rate, locate your state of residence on this chart, then the first three digits of your zip code and notate the corresponding Region number. Use this Region to determine your premiums from the Dental Plan Summary.

The MetLife Dental Plan is subject to state approval and is currently not available to Members residing in Maine or Puerto Rico.

| State | Region | 3 Digit Zip Codes |
|---------------------------|--------|---|
| Alabama (AL) | 1 | 350 - 352, 354 – 369 |
| Alaska (AK) | 4 | 995 – 999 |
| Arkansas (AR) | 1 | 716 - 720, 722 – 726, 728, 729 |
| | 2 | 721,727 |
| Arizona (AZ) | 1 | 857 |
| | 2 | 850, 852, 853, 855, 856, 859, 860, 863 – 865 |
| California (CA) | 2 | 917 - 925, 936 - 938, 953 |
| | 3 | 900 - 908, 912 - 916, 926 - 928, 930, 932 - 934, 952, 955 – 961 |
| | 4 | 910, 911, 931, 935, 939 - 951, 954 |
| Colorado (CO) | 2 | 800 - 802, 804 - 807, 809 – 815 |
| | 3 | 803, 808 |
| | 4 | 816 |
| Connecticut (CT) | 3 | 060, 063, 064, 066, 067 |
| | 4 | 061, 062, 065, 068, 069 |
| Delaware | 4 | 197 – 199 |
| District of Columbia (DC) | 2 | 200, 202 – 205 |
| Florida (FL) | 1 | 320 - 329, 333 - 339, 342, 344, 346, 347, 349 |
| | 2 | 330 - 332, 341 |
| Georgia (GA) | 1 | 304, 307 - 310, 312 |
| | 2 | 300 -303, 305, 306, 311, 313 - 319, 398 |
| Hawaii (HI) | 2 | 967, 968 |
| Illinois (IL) | 1 | 604, 605, 609 - 620, 622 – 629 600 - 603, 606 - 608 |
| Indiana (IN) | 1 | 460 - 465, 469, 471 – 478 |
| | 2 | 466 – 468, 470, 479 |
| Iowa (IA) | 1 | 500 - 502, 504 - 510, 512 - 516, 520 – 528 |
| | 2 | 503 |
| | 3 | 511 |
| Idaho (ID) | 1 | 832, 833, 834, 835, 838 |
| Kansas (KS) | 1 | 661, 667, 668, 669, 671, 673 – 679 |
| | 2 | 660, 662, 664 - 666, 670, 672 |
| Kentucky (KY) | 1 | 400 - 418, 421 – 427 |
| | 2 | 420 |
| Louisiana (LA) | 1 | 700, 701, 703, 704 - 708, 710 – 714 |
| Maryland (MD) | 1 | 206, 210 - 212, 214 – 219 |
| | 2 | 207 – 209 |
| Massachusetts (MA) | 2 | 010, 012, 013 |
| | 3 | 011, 014 – 027 |

| | | |
|---------------------|---|--|
| Michigan (MI) | 1 | 486, 487 |
| | 2 | 484, 485, 488- 499 |
| | 3 | 480 – 483 |
| Minnesota (MN) | 1 | 561, 562, 564 – 567 |
| | 2 | 550, 551, 553 - 556, 559 - 560, 563 |
| | 3 | 557, 558 |
| Missouri (MO) | 1 | 630 - 633, 635 - 641, 644 – 657 |
| | 2 | 634, 658 |
| Mississippi (MS) | 1 | 386 – 395 |
| | 2 | 396, 397 |
| Montana (MT) | 2 | 590 - 597, 599 |
| | 3 | 598 |
| Nebraska (NE) | 1 | 680, 681, 683 – 693 |
| New Hampshire (NH) | 4 | 030 – 038 |
| North Carolina (NC) | 2 | 270, 278, 279, 283 -286 |
| | 3 | 271 – 277, 280 - 282, 287 – 289 |
| North Dakota (ND) | 2 | 580 – 588 |
| New Jersey (NJ) | 2 | 070 - 073, 077, 080 - 084, 086, 087 |
| | 3 | 074 - 076, 078, 079, 085, 088, 089 |
| Nevada | 2 | 889 – 891 |
| | 3 | 893, 898 |
| | 4 | 894, 895, 897 |
| New Mexico (NM) | 2 | 870 - 875, 877 - 884 |
| New York (NY) | 1 | 120 - 126, 140 - 143, 147 – 149 |
| | 2 | 103, 104, 109 - 119, 127 - 139, 144 – 146 |
| | 3 | 100 - 102, 105 – 108 |
| Ohio (OH) | 1 | 430 - 450, 452 - 456, 458, 459 |
| | 2 | 451 |
| | 3 | 457 |
| Oklahoma (OK) | 1 | 730, 731, 733, 734, 736 - 741, 743 – 749 |
| | 2 | 735 |
| Oregon (OR) | 3 | 970 - 979 |
| Pennsylvania (PA) | 1 | 150 - 168, 170 - 174, 180, 182 - 188, 190 – 192 |
| | 2 | 169, 175 - 179, 181, 189, 193 – 196 |
| Rhode Island | 3 | 028, 029 |
| South Carolina (SC) | 2 | 290 – 299 |
| South Dakota (SD) | 2 | 570 – 577 |
| Tennessee (TN) | 1 | 370 - 372, 374 -375, 377 - 379, 380 – 385 |
| | 2 | 373, 376 |
| Texas (TX) | 1 | 750 – 753, 755-764, 766-777, 779-799 |
| | 2 | 754, 765, 778, 885 |
| Utah (UT) | 1 | 840 - 847 |
| Virginia (VA) | 1 | 224, 225, 227, 228, 230 - 233, 236, 238 - 244, 246 |
| | 2 | 201 220 – 223, 226, 229, 234, 235, 237, 245 |
| Vermont (VT) | 2 | 008 |
| | 3 | 050 - 054, 056 – 59 |
| Washington (WA) | 3 | 990-992,994 |
| | 4 | 980-989, 993 |
| Wisconsin (WI) | 1 | 530 - 532, 534, 535, 538 -549 |
| | 2 | 537 |

| | | |
|--------------------|---|--|
| West Virginia (WV) | 1 | 247, 248, 250 - 253, 255 - 258, 260, 262 – 268 |
| | 2 | 249, 259, 261 |
| | 3 | 254 |
| Wyoming (WY) | 1 | 820 -831 |

DECLARATION SECTION

The person signing below declares that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief.

For Changes Requested After Initial Enrollment Period Expires

I understand that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas, Oregon, and Vermont: Any person who knowingly and with intent to defraud any insurance company 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia and Washington: 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.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.

Signature(s): The member must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.



Member Signature

Print Name

Date Signed (Mo./Day/Yr.)



**AFA Veteran Benefits Association
Dental Insurance
Payment Authorization**

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number including area code (_____) _____

E-Mail Address _____

Payment Instructions

Based on my plan selection and Region, my monthly premium is \$_____.

I prefer to make an annual payment:

• Attached is my check for \$ _____ (monthly premium x12); or

• Please charge my VISA MasterCard

Credit Card #: - - - Exp. Date: /

I prefer to make monthly payments and authorize AFAVBA to:

Charge premiums on the 15th of every month to my VISA MasterCard

Credit Card #: - - - Exp. Date: /

Debit monthly premiums from the following bank account on the 1st business day of every month:

Please attach a VOIDED check

Routing #: _____ (9 digits)

Bank Account #: _____

Signature: _____ Date: _____

Please mail or fax the enrollment form and payment authorization form to:

AFAVBA Member Benefits, 1501 Lee Hwy., Arlington, VA 22209-1198 * Fax 703-247-5853