

A City of Houston Payroll Deduction Authorization and Cancellation Form

I, _____ hereby authorize the City of Houston to
Print Employee Name
 deduct/stop _____ from my pay each scheduled cycle and remit to
(circle one) Amount

Texas Police Trust 1600 State Street Houston, Texas 77007
Company Name and Address

Veronica Mc Donough 832-200-3410 in payment of goods and services purchased by me.
Agent/Representative Agent's Phone

I understand the City of Houston neither sponsors nor endorses the product or services purchased from the above company, nor does it attest to the worth or value of the product or service. I understand, except when restrictions by federal laws apply, that I may cancel this authorization at any time, in writing, by executing a Form 6 (revised 10/91). In consideration of the City providing this service, I agree not to hold the City liable for any loss resulting from failure to deduct and/or remit the payment specified. I will pay directly to the company any monies not withheld during a payroll cycle. I further authorize increases or reductions in such deductions. I will request directly from the company any change to my address; however, if I fail to do so, I authorize the City to release my address of record to the company. I certify that no portion of this deduction is for a Political Action Contribution (PAC) or any other purpose prohibited by City of Houston Legislation. I further agree to notify the company or agent, listed above, in writing of any changes or cancellations to my coverage 30 days prior to the effective date of change. Additionally I will not hold the company or agent responsible for changes made by parties other than the company or agent or incorrect deductions over 30 days old.

Employee Signature _____ Date Signed _____

--To be completed by payroll clerk--

Employee Number _____

Employee SS# _____ Dept. _____ Dept. Name _____

Check appropriate box(es)	Amount	Type/Plan	Date	Name
<input checked="" type="checkbox"/> Start Amount	_____	HPOAD / HPOAD	_____	_____
<input type="checkbox"/> Change if new amt.	_____	_____ / _____	_____	_____
<input type="checkbox"/> Stop Amount	_____	_____ / _____	_____	_____
<input type="checkbox"/> One-time Deduction	_____	_____ / _____	_____	_____
<input type="checkbox"/> One-time Refund	_____	_____ / _____	_____	_____

Payroll Clerk Date Prepared Department Head

DUAL CHOICE ENROLLMENT APPLICATION

CHOICE ONE- PREPAID

ENROLLMENT INSTRUCTIONS:

1. Complete the application. (Be sure to list all Family Members to be included.)
2. **Select a dental office from the Provider List and Insert the dental facility number on the application.**
3. Complete the authorization for deduction with full information and sign in the lower portion.
4. Return the completed application and authorization for deduction to your payroll department for processing.

Completed applications, with correct premiums, received by Home Office by the 15th of the month will become effective on the 1st of the following month.

SOCIAL SECURITY #		LAST NAME		FIRST	MI	DATE OF BIRTH	
HOME ADDRESS				AREA CODE	HOME PHONE		SEX <input type="checkbox"/> M <input type="checkbox"/> F
CITY		STATE	ZIP CODE	AREA CODE	BUSINESS PHONE		DENTAL FACILITY #
NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION							
LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED							
FIRST		M.I.	LAST		S.S.N. #		SEX <input type="checkbox"/> M <input type="checkbox"/> F
BIRTHDATE							
SPOUSE:							
						<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD:							
						<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD:							
						<input type="checkbox"/> M <input type="checkbox"/> F	
EFFECTIVE DATE							
PLAN CODE	GROUP CODE #	PREMIUM AMOUNT	AMOUNT PAID	AGENT CODE			
		\$	\$				

I wish to enroll in the Prepaid Plan. I understand that this is a minimum one (1) year contract and that all necessary dental services will be provided in the description of benefits and surcharges. I have received and understand the outline of coverage.

Applicant's Signature: _____ Date: _____
Agent's Signature: _____

CHOICE TWO

Insured by CompDent Insurance Company, Roswell, Georgia

ENROLLMENT INSTRUCTIONS:

1. Complete the application. (Be sure to list all Family Members to be included.)
2. Complete the authorization for deduction with full information and sign in the lower portion.
3. Return the completed application and authorization for deduction to your payroll department for processing.

Completed applications, with correct premiums, received by Home Office by the 15th of the month will become effective on the 1st of the following month.

SOCIAL SECURITY #		LAST NAME		FIRST	MI	DATE OF BIRTH	
HOME ADDRESS				AREA CODE	HOME PHONE		SEX <input type="checkbox"/> M <input type="checkbox"/> F
CITY		STATE	ZIP CODE	AREA CODE	BUSINESS PHONE		
NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION				OCCUPATION (TITLE)		DATE HIRED FULL TIME	
LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED							
FIRST		M.I.	LAST		S.S.N. #		SEX <input type="checkbox"/> M <input type="checkbox"/> F
BIRTHDATE							
SPOUSE:							
						<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD:							
						<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD:							
						<input type="checkbox"/> M <input type="checkbox"/> F	
BENEFICIARY NAME AND RELATIONSHIP (i.e., Mary Jones, Wife)							
EFFECTIVE DATE	PLAN CODE	GROUP CODE #	PREMIUM AMOUNT	AMOUNT PAID	AGENT CODE		
			\$	\$			

I wish to enroll in the Choice Two dental plan. I have received and understand the outline of coverage.

Applicant's Signature: _____ Date: _____
Agent's Signature: _____

Please Note:

Any person who, 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. I hereby consent, personally and on behalf of any family members enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to CompDent for, but not limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.

AUTHORIZATION FOR DEDUCTION – Signature Required – Employer

Name _____ Social Security No. _____ I authorize _____ (Employer, Financial, or other organization)

To make Weekly Bi-Weekly Semi-Monthly Monthly (Check correct payment method) Deductions of \$ _____ From: My salary or other compensation

and to remit the amount deducted to **CompDent (CD)**, upon instruction from **CD**. The amount of deduction indicated above is approximate and may be corrected as instructed by **CD**. This authorization shall cease (a) upon my giving written cancellation notice to you; or (b) automatically upon my termination as a member or depositor, as the case may be, of the above named organization. I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by **CD** and if this authorization terminates for any reason, any further payments required under said policy (ies) shall be made as provided in the policy (ies). I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent for **CD**.

Applicant's Signature: _____ Date Signed: _____

Because we specialize in dental, we can bring you benefits and service that other companies can't match!

➤ **QUICK CLAIMS TURNAROUND**

CompBenefits' state of the art claims center provides fast reimbursement of your claims.

➤ **ACCESS TO INFORMATION**

Our toll-free customer service number at 1-(800)-342-5209 has Member Services Representatives who can provide the answers you need quickly and thoroughly.

➤ **TOTAL FREEDOM OF CHOICE**

The plan provides you with total freedom of choice by allowing you to use any licensed dentist for treatment. The plan reimburses a percentage of eligible expenses based on the plan you have chosen.

Any way you add it up, CompBenefits really is the benefits company of choice!

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures, is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

*Coverage based on usual, customary and reasonable fees.

**Time served on the employer's immediately preceding group dental plan may be credited towards this plan's waiting periods, subject to Underwriting approval.

***Maximum of 3 per family.

CompBenefits Family of Companies

CompDent • CompBenefits Insurance Company
 American Dental Plan, Inc. • American Dental Plan of North Carolina, Inc.
 Oral Health Services, Inc. • National Dental Plans, Inc.
 Texas Dental Plans, Inc. • VisionCare, Inc. • VisionCare Plan
 Primary Plus • Ultimate Optical, Inc.

SUMMARY OF BENEFITS

Partial Listing of Covered Services	In-Network Reimbursements	Out-of-Network Reimbursements
-------------------------------------	---------------------------	-------------------------------

Type I Diagnostic & Preventive...100%.....100%

- Oral Examination (once per six months)
- Prophylaxis (cleaning, once per six months)
- Topical Fluoride (children under 16,once per 12 months)
- X-Rays (limitations may apply)
- Sealants (once per 3 years for children under age 16, for non carious molars only)
- Space Maintainers (for children under age 16)

Type II Basic Services..... 80%.....80%

- Simple Restorative (amalgam, synthetic, or composite fillings)
- Emergency Palliative Treatment
- Tooth Extraction
- Endodontics (root canals)
- Periodontics (includes treatment of diseases of the gums)

Type III Major Services.....50%.....50%

- Major Restorative (crowns/inlays/onlays)
- Bridge, Denture Repair
- Prosthetics (bridges and dentures)

Type IV Orthodontics50%.....50%

(12 month waiting period**) Dependent children 18 years of age or younger

MAXIMUM BENEFITS

	Insured Individual	and Dependents
Lifetime		
Type I, II, III.....	Unlimited.....	Unlimited
Type IV.....	\$1,000.....	\$1,000
Calendar Year		
Type I, II, III.....	\$1,500.....	\$1,500
Type IV.....	\$500.....	\$500
Deductible***		
Type I.....	None.....	None
Type II, III, IV.....	\$50.....	\$50

MAJOR RESTORATIVE LIMITATIONS

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. the denture or partial denture must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
2. the fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
3. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
4. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
5. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
6. the replacement of teeth up to the normal complement of 32.

EXCLUSIONS

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits Insurance Company;
3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. charges for travel time; transportation costs; or professional advice given on the phone;

8. procedures performed by a Dentist who is a member of Your immediate family;
9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of \$100 (US dollars) per year;
13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. treatment for cosmetic purposes. Facings on crowns or bridge units on molar teeth will always be considered cosmetic;
15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
17. a sickness for which the patient can receive benefits under a workers' compensation act or similar law;
18. an injury that arises out of or in the course of a job or employment for pay or profit;
19. charges to the extent that they are more than the Prevailing Fee. If the amount of the Prevailing Fee for a service cannot be determined due to the unusual nature of the service, CompBenefits Insurance Company will determine the amount. CompBenefits Insurance Company will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors; or
20. orthodontic plan benefits for persons 19 years of age or older.

PREDETERMINATION

If Covered Dental Expenses for a procedure are expected to be more than \$200 it is recommended that you send a Dental Treatment Plan in prior to beginning treatment, send preauthorization to CompBenefits, P.O. Box 8236 Chicago, IL 60680-8236. You and/or your dentist will be notified of the benefits payable based upon the Dental Treatment Plan.

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures is found in the Schedule of Benefits and Certificate of Group Dental Insurance.