

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), 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...



Dental and Vision for Everyone: Dental Price Areas

Indemnity Plan

States	Zip Code	Area
Alaska	995-996	7
	All Others	6
California	900-905, 915-918	7
	956-958	4
	906-914, 919-927, 930-939	6
	949, 952, 955, 959-961	6
	All Others	5
Colorado	803, 808-810	4
	All Others	1
Connecticut	068-069	6
	All Others	5
Delaware	All	2
Florida	320-322	4
	330-334	5
	All Others	3
Georgia	300-303	2
	All Others	3
Idaho	All	3
Illinois	600-605	2
	606-608	3
	All Others	1
Indiana	463-464	3
	473	2
	All Others	1
Iowa	All	1
Kansas	660-662	2
	All Others	1
Kentucky	All	1
Maryland	207-212	4
	All Others	2
Michigan	480-483, 490-491	2
	488-489	3
	All Others	1
Minnesota	554	3
	550-553, 555	2
	All Others	1
Missouri	640-641, 644-648	2
	All Others	1
Nebraska	All	1
New Mexico	881	2
	882	5
	All Others	1
Nevada	893-898	5
	All Others	4
North Carolina	277, 287-289	2
	286	3
	All Others	1

DPO Plan

States	Zip Code	Area
Alaska	995-996	7
	All Others	6
California	900-905, 915-918	7
	956-958	4
	906-914, 919-927, 930-939	6
	949, 952, 955, 959-961	6
	All Others	5
Colorado	803, 808-810	4
	All Others	1
Connecticut	068-069	6
	All Others	5
Delaware	All	2
Florida	320-322	4
	330-334	5
	All Others	3
Georgia	300-303	1
	All Others	2
Illinois	600-605	2
	606-608	2
	All Others	1
Indiana	463-464	2
	All Others	1
Iowa	All	1
Kansas	660-662	2
	All Others	1
Kentucky	All	2
Maryland	207-212	3
	All Others	2
Michigan	480-483, 490-491	2
	488-489	3
	All Others	1
Minnesota	554	3
	550-553, 555	2
	All Others	1
Missouri	640-641, 644-648	2
	All Others	1
Nebraska	All	1
New Mexico	881	2
	882	5
	All Others	1
Nevada	893-898	5
	All Others	4
North Carolina	277, 287-289	4
	286	5
	All Others	3

Dental price areas continued on reverse side...

Benefits Association, Inc. Enrollment Form: (Signature Required)

Social Security No.	Primary Enrollee: Last Name			First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Phone	Street						Date _____
	City	State	Zip	Member Signature: _____			

"I hereby enroll in Benefits Association, Inc. To Purchase the insurance, you must first become a member of Benefits Association Inc. The BAI monthly membership fee is \$1.00 and is included in the monthly rates."

Member Signature: _____

Date _____

For additional information email MorganWhiteGroup at marketing@morganwhite.com or call 1-800-800-1397

Sign Here

Dental Price Areas (Cont.) – Indemnity Plan

States	Zip Code	Area
Ohio	430-436, 439-445	2
	450-452, 456	2
	All Others	1
Oregon	970-975	6
	All Others	5
Utah	All	5
Virginia	201, 220-221	5
	222-223	6
	224-225, 230-232	1
	228-229, 240-244	2
	All Others	4
West Virginia	255-257, 262-265	2
	All Others	1
Wisconsin	535-538	3
	All Others	4
Wyoming	All	1

Dental Price Areas (Cont.) – DPO Plan

States	Zip Code	Area
Ohio	430-436, 439-445	1
	450-452, 456	1
	All Others	1
Oregon	970-972	5
	All Others	4
Utah	All	5
Virginia	201, 220-221	5
	222-223	6
	224-225, 230-232	1
	228-229, 240-244	2
	All Others	4
West Virginia	255-257, 262-265	2
	All Others	1
Wisconsin	535-538	3
	All Others	4
Wyoming	All	1

Vision Monthly Rates

	Signature Choice	Exam Plus
Member	\$7.54	\$3.00
Member + 1	\$15.11	\$6.00
Member + Family	\$24.34	\$9.00

Dental Selection: <input type="checkbox"/> Indemnity Dental <input type="checkbox"/> DPO Dental Type of Coverage <input type="checkbox"/> Member <input type="checkbox"/> Member + 1 <input type="checkbox"/> Member + Family Optional Vision Coverage: <input type="checkbox"/> Exam Plus <input type="checkbox"/> Signature Choice				METHOD OF PAYMENT <input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Bankdraft: This is my authorization for Morgan-White Administrators, Inc., on behalf of Standard Life & Accident Insurance Company to draft payments from my checking account for payment of my insurance premiums. Below is the Routing Number and Checking Account number for the account on which drafts are to be drawn. Name of Bank: _____ Name as it appears on Check: _____ Routing Number (Bottom Left Corner of Check) _____ Account Number (2nd set of numbers on bottom) _____ <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard Credit Card #: _____ Exp. Date _____/_____/_____ Security Code _____ (3 digit code on back of card)	
Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Phone	Street				
	City		State		Zip
	E-mail address:				
LIST ALL DEPENDENTS TO BE COVERED BELOW					
Last Name (if different)		First Name	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
2. Spouse					<input type="checkbox"/> M <input type="checkbox"/> F
3. Dependents					<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
7.					<input type="checkbox"/> M <input type="checkbox"/> F
"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.					
Association Member's Signature _____					Date _____

For Agent Use Only AGENT NAME (if applicable): _____

AGENT # (Your state license #): _____