

The Maximum Value Dental Plan

Affordable Dental Insurance for You and Your Family

Insured by:



**American National Life Insurance Company of Texas
Galveston, Texas**

**Marketing General Agent
National Insurance Markets**

Phone: 412-782-1979

915 Saxonburg Blvd.

Suite 217

Pittsburgh, PA 15223

**Dental product for members of the
National Consumers Advantage Association**

MVP01-11

The Maximum Value Dental Plan

Affordable Dental Insurance for You and Your Family

Choose ANY Dentist

Dental Care Description

Preventive Services - Class A

80% - UCR

No Waiting Periods

- Two routine exams per year no less than 6 months apart
- Two routine cleanings per year no less than 6 months apart
- One topical fluoride per year to age 16
- One series of bitewing x-rays per year

Basic Services - Class B

50% - UCR

No Waiting Period

- Simple extractions
- Fillings

Deductible / Co-Pays

\$50 Calendar Year Deductible - Per Person

\$10 Per Office Visit Co-Pay - Per Person

\$500 Calendar Year Maximum - Per Person

Choose ANY Dentist

Rates Effective January 1, 2011

	Per Adult	Per Child
Area 1	\$17.27	\$ 8.26
Area 2	\$18.85	\$ 9.21
Area 3	\$20.42	\$10.15
Area 4	\$21.26	\$10.66
Area 5	\$21.99	\$11.09
Area 6	\$23.57	\$12.04
Area 7	\$25.14	\$12.98
Area 8	\$27.18	\$14.21
Area 9	\$30.57	\$16.24

Adults #	_____	Premium \$	_____
Children #	_____	Premium \$	_____
		Admin Fee \$	2.00
		NCAA Fee \$	1.00
		TOTAL \$	_____

Insured by:



American National Life Insurance Company of
Texas
Galveston, Texas

State	Area	State	Area
Alaska	9	Michigan	2
Arizona	2	480-485	3
850-853	3	Mississippi	1
Arkansas	1	Missouri	1
California	5	630-634	2
900-904	7	640-641	2
905-916	6	640-641	2
926-931	6	Nebraska	1
940-944	7	Nevada	5
945-951	6	893-898	6
Colorado	3	New Mexico	2
800-804	5	North Carolina	2
808-809	5	275-277	3
Delaware	6	282	5
Dist of Columbia	6	North Dakota	1
Georgia	2	Ohio	1
301-302	3	430-432,434-436	2
300,303,311	5	439-445,450-452,456	2
Hawaii	5	Oklahoma	1
Idaho	1	730-731,740-741	2
837	3	Pennsylvania	2
Illinois	1	190-191	3
600,600-608	5	189,192-194	5
610-619	2	Rhode Island	3
Indiana	1	South Carolina	2
460-466,469,473	2	Tennessee	1
Iowa	1	370-372,380-384	2
Kansas	1	Texas	1
660-661,664-666,672	2	762-764,768-769	2
Kentucky	1	788,790-799	2
Louisiana	1	750,751,760,761,770	3
700-701	2	772-777,786,787,789	3
707-712	2	752-753	3
Maryland	2	Virginia	2
206-209	5	201	6
210-214	3	220-223	5
		233-237	3
		West Virginia	1
		Wisconsin	2
		532-534,537	3
		Wyoming	1

Exclusions

Benefits will not be paid for dental expenses arising from or in connection with:

- Treatment, services or supplies which:
- Are not Medically Necessary;
- Are not prescribed by a Dentist;
- Are determined to be Experimental/ Investigational in nature by Us;
- Are received without charge or legal obligation to pay;
- Would not routinely be paid in the absence of insurance;
- Are received from any Family Member.
- Intentionally self-inflicted injuries.
- War or an act of war, whether or not declared.
- A Covered Person's commission of a felony.
- Participation in a riot.
- Employment, whether caused by, related to, or as a condition of, including self-employment. This exclusion applies even if Workers' Compensation or any Occupational Disease or similar law does not cover the charges.
- Treatment which began, before the Covered Person's Effective Date of coverage or after the Covered Person's termination of coverage.
- Congenital or development malformations existing when the Covered Person's coverage began effective under this Certificate.
- Cosmetic procedures.
- Surgical implants or transplants of any type including prosthetic devices attached to them.
- Temporomandibular joint syndrome.
- Periodontal splinting.
- Facings on crowns, or pontics posterior to the 2nd bicuspid.
- Replacement of partial or full dentures, fixed bridge work, crowns, gold restorations and jackets more often than once in any 5 year period.
- Relining of dentures more often than once in any 2 year period.
- Lost, stolen, or missing dentures or bridges or for duplicates.
- Fixed or removable bridgework involving replacement of a natural tooth or teeth which was lost prior to the Covered Person's Effective

Date of coverage under this Certificate. Benefits may be payable for bridgework required for loss of teeth while covered under this Certificate, if such bridgework is not an abutment for non-covered bridgework.

- Prescription Drugs and analgesia pre-medication.
- Charges for telephone consultations, failure to keep a scheduled appointment, to complete claim forms or attending Dentist statements, and any other services or supplies which are not part of the direct treatment of the Covered Person.
- Dental education or training programs including oral hygiene or plaque control programs.
- Counseling on diet and nutrition.
- Expense related to a Covered Person's military service, including service in a military reserve unit.
- Orthodontia, unless this coverage is elected by the Policyholder and the required premium is paid.
- Prosthodontics, unless this coverage is elected by the Policyholder and the required premium is paid.
- Charges payable under any medical insurance.
- Charges made by any government entity unless the Covered Person is required to pay.
- Use of materials, other than fluorides or sealants, to prevent tooth decay.
- Bite registrations.
- Bacteriologic cultures in connection with a covered dental service.
- Therapeutic injections administered by a Dentist.

Insured by:



American National Life Insurance Company of Texas
Galveston, Texas

A full explanation of benefits, exceptions and limitations contained in the Policy (form series DENT06-POL) is found in the policy issued to your Association.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

One Moody Plaza, Galveston, Texas 77550

Distributed by: Marketing Benefits Inc.

P.O. Box 1459

Orange Beach, AL 36561

The Maximum Value Dental Plan**DENTAL ENROLLMENT APPLICATION
FOR MEMBERS OF THE NATIONAL CONSUMERS ADVANTAGE ASSOCIATION**

Please print in the space provided

ASSOCIATION INFORMATION

Association Name: National Consumers Advantage Association

Policy Number: DENT062007

APPLICANT

Last Name:	First Name:	M.I.:
Street Address:	City:	State:
Social Security Number:	Telephone Number:	Email Address:
		Birth Date:

COVERAGE – Check Those That Apply
 Myself/Applicant Spouse Children Requested Effective Date: _____
DEPENDENT INFORMATION (if applicable)

Spouse Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (MM-DD-YY):	
Child Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (MM-DD-YY):	Student (over age 19): <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (MM-DD-YY):	Student (over age 19): <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (MM-DD-YY):	Student (over age 19): <input type="checkbox"/> Yes <input type="checkbox"/> No

Will you or any Dependent have other dental insurance coverage? Yes No

If yes, please list the name of the other insurance company and phone number: _____

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any DependentI decline coverage for: Myself/Applicant Spouse My Children

Reason for refusal: _____

PREMIUM

\$ _____ Select Payment Mode: Annual Semi-annual Quarterly Monthly Monthly Bank Draft

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the American National Life Insurance Company of Texas group dental plan offered by the National Consumers Advantage Association. I, the undersigned applicant, have personally completed the enrollment application and represent that all answers are true and complete to the best of my knowledge and belief. The statements in this enrollment application are deemed to be representations and not warranties. I understand and agree that the insurance will not take effect unless the enrollment application has been accepted and approved by American National Life Insurance Company of Texas and until the effective date of the Certificate, if issued.

Warning: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

DATE: _____ CITY AND STATE: _____

SIGNATURE OF APPLICANT: _____

Agent Name: _____	Address: _____	Phone: _____	E Mail: _____
General Agent: _____	Address: _____	Phone: _____	E Mail: _____

DENT06-ENR

ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION FORM

Attach a voided check

As a duly authorized check signer on the bank/financial institution account identified above, I authorize Employer Plan Services, Inc. to perform monthly electronic funds transfer debits from my account identified above for payments due.

This authorization remains in effect until I submit an updated EFT Authorization Form requesting termination and until such time that Employer Plan Services, Inc. has had a reasonable opportunity to act on such request. If my bank/financial institution information changes, I agree to submit an updated EFT authorization form.

Signature

Date

NATIONAL CONSUMER ADVANTAGE ASSOCIATION ENROLLMENT

I understand that in order to purchase this Dental Insurance plan, I must first become a member of the National Consumer's Advantage Association (NCAA). I understand that NCAA members are entitled to receive Car Rental Discount Coupons, Vision Care Discounts, Travel Club Benefits, and various other consumer and discount materials. Under Bylaws of the Association now or as amended, with resulting cost savings that ultimately benefit me as a member, by delivery of this signed enrollment form to NCAA, I appoint its President as my proxy to vote and otherwise act. This proxy shall be of no effect at any meeting that I personally attend. I hereby apply for membership in the National Consumer's Advantage Association. I understand that membership dues are \$1.00 monthly and are to be drafted from my account along with the premium for the dental insurance plan.

Signature

Date