Rising healthcare costs can force you into difficult situations including reduced health benefits, loss of benefits, and price increases. Basic Medicare does not cover dental, vision or hearing expenses. Medicare supplemental policies may provide some coverage, but not all. From big businesses to self employed and retired individuals, we all feel the effects of rising healthcare costs. Discover the benefits and security you need with Southwest Service Life Insurance Company’s Dental, Vision and Hearing Insurance.
Benefits
After the Annual Deductible is satisfied, we will pay the following percentages directly to you, subject to reasonable and customary, up to the annual maximum benefit:

- 60% of covered expenses in the first Policy Year.
- 70% of covered expenses in the second Policy Year.
- 80% of covered expenses in the third Policy Year.
- 90% of covered expenses thereafter.

Choose Your Deductible
You may choose between a $0 or $100 per Insured per Policy Year Deductible. This is the amount you are responsible for during each Policy Year before benefits are payable.

Choose Your Maximum Benefit
Per Insured per Policy Year Maximum Benefit is the maximum benefit amount that Policy will pay during any one Policy Year. You may choose $1,000, $1,500 or $2,000.

WHO IS ELIGIBLE?
Anyone ages 18-84.

Covered Expenses
We will pay the applicable percentage for the following services performed by a licensed dentist, physician or audiologist:

DENTAL
- Day one-X-rays, fillings and outpatient dental surgery prescribed as Medically Necessary.
- After a three month waiting period - one annual cleaning up to $75. (not subject to deductible)
- After a six month waiting period - root canals.
- After a one year waiting period - bridges, crowns, dentures, work relating to replacement of natural teeth missing on the Policy Effective Date, full mouth extractions and fluoride treatments.

VISION
MAXIMUM BENEFIT IS $150
- Day one-One annual basic eye examination or eye refraction, including the cost of eyeglasses or prescribed contact lenses.
After a six month waiting period-repair or replacement of existing eyeglasses or contact lens. (including the renewal or changing of prescriptions)

HEARING
- Day one - Hearing examinations, including the cost of the hearing aid and any necessary repairs.
- After a one year waiting period-repair or replacement of existing hearing aids.

Guaranteed Renewable for Life
This Policy is renewable as long as you live, provided you continue to pay premiums when due.

No Networks! You Choose the Provider
Pays in addition to any other coverage
Benefits are paid directly to you
No worries about whether or not your doctor or dentist is in a network. No hassles about where you can buy glasses or hearing aids. You decide who to see. We provide the coverage.
**Dental, Hearing and Vision Policy Form DVH-101**

### Part 1 READ YOUR POLICY CAREFULLY.
This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Southwest Service Life. It is therefore important that you READ YOUR POLICY CAREFULLY.

### Part 2 Dental, Vision and Hearing only coverage is designed to provide you with coverage for certain losses for dental, vision and hearing ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses.

### Part 3 Benefits

<table>
<thead>
<tr>
<th>A. After the Policy Year Deductible, if any, is satisfied, the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>60% in the first Policy Year</td>
</tr>
<tr>
<td>70% in the second Policy Year</td>
</tr>
<tr>
<td>80% in the third Policy Year</td>
</tr>
<tr>
<td>90% thereafter</td>
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</table>

**COVERED EXPENSES, SUBJECT TO THE LIMITATIONS AND EXCLUSIONS**

**B. Dental Benefits**

We will pay the applicable percentage for dental services performed by a licensed Dentist, including one annual examination and cleaning, x-rays, fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.

After the Policy has been in force three (3) months, the Company will pay the cost of one (1) dental cleaning up to a maximum benefit of $75 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for root canals.

We will NOT pay benefits during the first Policy Year for the following items and/or services: Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing on the Policy Effective Date, “full mouth” extractions or fluoride treatments;

**C. Hearing Benefits**

We will pay the applicable percentage for hearing examinations performed by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

We will NOT pay benefits during the first Policy Year for existing hearing aids.

**D. Vision Benefits**

We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one (1) Policy Year.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).
Part 4. LIMITATIONS AND EXCLUSIONS - READ CAREFULLY

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page. Each Insured must satisfy the Policy Year Deductible Amount in full before benefits are payable for that insured.

THE POLICY DOES NOT PROVIDE BENEFITS FOR

We will NOT pay benefits for: 1.) any loss resulting from war, declared or undeclared; or 2.) any intentionally self-inflicted Injury; or 3.) any loss resulting from the commission of or the attempt to commit an assault or felony; or 4.) any loss resulting from engaging in any illegal activity or occupation; or 5.) any services that are not recommended by a Physician or other licensed medical professional; or 6.) any Experimental or Investigational Procedure or Treatment; or 7.) orthodontic treatment; or 8.) any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or 9.) expenses incurred for surgical procedures [other than outpatient dental surgery] performed on an inpatient or outpatient basis [including any surgical procedure performed for the treatment of cataracts]; or 10.) charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or 11.) prescription drugs; or 12.) charges in excess of Reasonable and Customary Charges; or 13.) treatment or diagnosis received while outside the United States of America or its territories; or 14.) services for which you are not liable or for which no charge normally is made in the absence of insurance; or 15.) loss that occurs while this Policy is not in force.

Part 5. RENEWABILITY - The policy is guaranteed renewable for life. We will renew the policy each time you send us a premium. It must be paid on or before the date it is due or during the 31 days that follow.

PREMIUM CHANGE

We may change the premium rates for the policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class and in the same state where your policy was issued.

TEN-DAY RIGHT TO EXAMINE AND RETURN POLICY

If for any reason You are not satisfied with your Policy, You may return the Policy within ten [10] days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded.

Policy Year Maximum Benefit:
- ☐ $1,000
- ☐ $1,500
- ☐ $2,000

Deductible Options:
- ☐ $0 or ☐ $100
- ☐ $0 or ☐ $100
- ☐ $0 or ☐ $100

☐ Monthly ☐ Monthly Bank Draft ☐ Quarterly - 3 times the monthly rate
☐ Semi-Annual - 6 times the monthly rate ☐ Annual - 12 times the monthly rate

DISCLOSURE OF LIMITED AUTHORITY Your application was taken by a soliciting agent whose authority is limited only to providing you with an outline of coverage and an application, assisting you, if necessary, in filling out the application, and then transmitting your application and initial premium to the Home Office. Your agent does not have the authority to waive a complete answer to any question on your application, or to approve insurability nor the authority to make or alter any provisions of the outline of coverage, application, or Certificate. Your agent does not have the authority to waive any rights of the Company and You will not be insured until a Policy is actually issued by the Company. The making of an application and the payment of an initial premium does not guarantee your insurability and does not mean that you are insured by the Company.

Receipt for Advance Premium Payment

Received of ............................................................... $ ............................................

for the first premium beginning with the date of the Policy. These amounts will be returned if a Policy is not issued. Please notify our office if the Policy is not received within 45 days. It is very important that the complete medical history be recorded on the application. It is distinctly understood that the Policy applied for is not effective until actually issued by the Company, and the Company is not liable for any loss whatsoever sustained before the Policy is actually issued by the Company, and is then liable only as provided and limited in the Policy. All benefits are subject to Policy provisions. No oral statement by or to the soliciting representative shall be effective to alter any written provisions of the application of the insurance Policy, if any, when same may be issued by the Company.

SOUTHWEST SERVICE LIFE INSURANCE COMPANY

Date ............................................ 20 ...................... Soliciting Representative ...............................................................
License Number ...............................................................
Form No. DVH-101

Southwest Service Life Insurance Company, Fort Worth, Texas  P.O. Box 982005, Fort Worth, Texas 76182  Phone 1-800-966-7491
**Benefit Options DVH-101**

<table>
<thead>
<tr>
<th>Policy Year</th>
<th>Deductible Options</th>
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<tbody>
<tr>
<td>☐ $1,000</td>
<td>☐ $0    ☐ $100</td>
</tr>
<tr>
<td>☐ $1,500</td>
<td>☐ $0    ☐ $100</td>
</tr>
<tr>
<td>☐ $2,000</td>
<td>☐ $0    ☐ $100</td>
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**SOUTHWEST SERVICE LIFE INSURANCE COMPANY**

(A STIPULATED PREMIUM COMPANY) FORT WORTH, TEXAS

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Special Request</th>
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</table>

**Billing Mode:** ☐ Monthly  ☐ Monthly Bank Draft  
**Mail Policy to:**  
**REP#**

<table>
<thead>
<tr>
<th>Names of Applicants</th>
<th>Relationship to Applicant</th>
<th>Age</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
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</thead>
<tbody>
<tr>
<td>1. Applicant</td>
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<td>2.</td>
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<table>
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<tr>
<th>ADDRESS:</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<table>
<thead>
<tr>
<th>Name of Applicant’s Employer</th>
<th>Applicant’s Occupation</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Name of Spouse’s Employer</th>
<th>Spouse’s Occupation</th>
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</table>

<table>
<thead>
<tr>
<th>List other coverage or any pending Dental, Vision, or Hearing Insurance applicant may have. Name of Company.</th>
<th>Is Policy to be Replaced?</th>
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<tbody>
<tr>
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<td>Yes  No  When?</td>
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<table>
<thead>
<tr>
<th>Applicant’s Home Telephone</th>
<th>Work Telephone</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Mobile Telephone</th>
<th>E-Mail Address</th>
</tr>
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<tbody>
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</table>

**Medical Information**

1. Do you currently wear dentures?  ☐ Yes  ☐ No
2. Have you been advised to have any dental work which has not been completed? If “Yes”, provide details:  ☐ Yes  ☐ No
3. Do you currently wear eyeglasses or contact lenses?  ☐ Yes  ☐ No
4. Have you received advice or treatment within the past nine (9) months for correction of a vision problem? If yes, provide details:  ☐ Yes  ☐ No
5. Do you currently wear a hearing aid?  ☐ Yes  ☐ No
6. Have you been treated for hearing loss within the past nine (9) months?  ☐ Yes  ☐ No
7. Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?  ☐ Yes  ☐ No

**Name of Applicant's Dentist**
**Address**

**Name of Spouse's Dentist**
**Address**

**Applicant's Home Telephone**
**Work Telephone**

**Have you or any member listed ever been declined, restricted, rated up or postponed for any kind of personal insurance?** ☐ Yes  ☐ No  If “Yes”, Name of Company.

**Why?**

**Are any applicants covered by Medicare or Medicaid?** ☐ Yes  ☐ No  If “Yes”, which applicant(s)

**Applicant’s Signature**:  

**APPLICANT OR SPOUSE MUST ANSWER ALL QUESTIONS IN FULL. YOUR REPRESENTATIVE DOES NOT HAVE AUTHORITY TO WAIVE OR OMIT ANY INFORMATION FROM YOUR APPLICATION.**
“I hereby apply to Southwest Service Life Insurance Company for a Policy to be issued solely and entirely in reliance on the written answers to the questions in this application. 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 Policy and (2) the agent does not have the authority to waive a complete answer as to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this application may bar the right to recover thereunder if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this application and all of the information contained herein. This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996, 45 CFR §164.508. It authorizes Southwest Service Life Insurance Co., to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purposes of insurance underwriting, risk review, claims adjudication and other health plan insurance operations. The person/people/entities authorized to make this disclosure to Southwest Service Life Insurance Co. are my physicians, medical practitioners, hospitals, clinics, medical facilities or other health care providers having records or knowledge of my health, and those of my family members whose names appear in my application for health insurance. The confidentiality of my health care information is waived by this authorization, which permits disclosure of any and all requested parts of my medical records. I understand this may include drug, alcohol, mental health, HIV and AIDS information. Southwest Service Life Insurance Co. will, within sixty days from the date written below, send me a copy of this authorization form as completed by me. This authorization is valid for two years following the date written below and will then expire. Under the Privacy Rules, I have a right to revoke this authorization at any time, and Southwest Service Life Insurance Co. must cease using this authorization. However, Southwest Service Life Insurance Co. may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Insurance Co., P.O. Box 982005, Fort Worth, Texas 76182-8005. A photocopy of this authorization is to be considered as valid as the original. This application for insurance is medically underwritten. My Policy may be issued as applied for or with either an exclusionary rider or a premium rating for a treated medical condition. I have received an outline of coverage for the Policy applied for.

I Certify I have accurately recorded herein the information supplied by the applicant and that an outline of coverage has been given to the applicant. Dated at (City, State)                                             (Month, Day, Year)

Representative's Signature X

Representative's Address

Applicant's Signature X

Spouse's Signature X

Amount Paid for Policy form DVH-101 $ for Initial and First Months Premium

AUTORIZATION TO HONOR CHECKS DRAWN BY SOUTHWEST SERVICE LIFE INSURANCE COMPANY, FORT WORTH, TEXAS 76182

TO: [BANK] Checking Account or Savings Account

Bank Address:

Routing Number: Account Number:

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of the Southwest Service Life Insurance Company, Fort Worth, Texas. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date Accountholder's Signature X

If personal account, need name & address of accountholder

If business account, need name & address of business
INSTRUCTIONS TO AGENT: This form is provided for the purpose of compliance with regulations regarding the replacement of accident and sickness insurance.

When the replacement questions on the application is answered YES, this form must be dated, signed by applicant, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Southwest Service Life Insurance Co.

For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, pre-existing conditions, may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may prove a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above “Notice to applicant” was delivered to me on: (DATE) ________________________________

Applicant’s Signature ________________________________________________________________
SOUTHWEST SERVICE LIFE INSURANCE CO.

IMPORTANT NOTICE
This Medical Records Authorization Form must be completed, signed and submitted with the initial application.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
COMPLIANT MEDICAL RECORDS AUTHORIZATION FORM

Patient/Primary Proposed Insured __________________________________________________________

Address: __________________________ City: __________________ Zip: __________ Date of Birth: ___ / ___ / ___

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996; 45 CFR §164.508. It authorizes Southwest Service Life Insurance Co. to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purposes of insurance underwriting, risk review, claims adjudication and other health plan insurance operations.

The person/people/entities authorized to make this disclosure to Southwest Service Life Insurance Co. is/are my physicians, medical practitioners, hospitals, clinics, medical facilities, or other health care providers having records or knowledge of my health, and those of my family members whose names appear in my application for health insurance.

The confidentiality of my health care information is waived by this authorization, which permits disclosure of any and all requested parts of my medical records. I understand that re-disclosure may not be protected. I also understand this may include drug, alcohol, mental health, HIV or AIDS information.

This authorization is valid for two years following the date written below and will then expire. Under the Privacy Rules, I have the right to revoke this authorization at any time, and Southwest Service Life Insurance Co. must cease using this authorization. However, Southwest Service Life Insurance Co. may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Insurance Co., P.O. Box 982005, Fort Worth, Texas 76182-8005.

Notice to my health care provider(s): An electronic signature on this HIPAA Compliant Medical Records Authorization Form has the same legal authority as a hand-written signature under both state and federal law. Please accept my e-signature as if it were my original hand-written signature.

Signature of Patient/Primary Proposed Insured __________________________________________ Date ___ / ___ / ___ Date of Birth: ___ / ___ / ___

Signature of Patient/Spouse (if proposed to be insured) __________________________________________ Date ___ / ___ / ___ Date of Birth: ___ / ___ / ___

Signatures of other Patients/Dependents 18 or over (if proposed to be insured)
________________________________________________________________________ Date ___ / ___ / ___ Date of Birth: ___ / ___ / ___

________________________________________________________________________ Date ___ / ___ / ___ Date of Birth: ___ / ___ / ___

________________________________________________________________________ Date ___ / ___ / ___ Date of Birth: ___ / ___ / ___

HIPAA MRA