

<i>SERFF Tracking Number:</i>	<i>ICCI-125582305</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>38625</i>
<i>Company Tracking Number:</i>	<i>PAN AM DEN-07-P</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Pan-Am DEN-07-P</i>		
<i>Project Name/Number:</i>	<i>Pan-Am DEN-07-P/Pan-Am DEN-07-P</i>		

Filing at a Glance

Company: Pan American Life Insurance Company

Product Name: Pan-Am DEN-07-P

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: ICCI-125582305

SERFF Status: Closed

Co Tr Num: PAN AM DEN-07-P

Co Status:

Author: Brenda Dawson

Date Submitted: 04/03/2008

State: ArkansasLH

State Tr Num: 38625

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 04/21/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Pan-Am DEN-07-P

Project Number: Pan-Am DEN-07-P

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/21/2008

State Status Changed: 04/21/2008

Corresponding Filing Tracking Number:

Filing Description:

See attached cover letter and forms.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small

Group Market Type: Association

Deemer Date:

Company and Contact

Filing Contact Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com

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Product Name: Pan-Am DEN-07-P
Project Name/Number: Pan-Am DEN-07-P/Pan-Am DEN-07-P

519 Colman Center Drive (815) 316-6714 [Phone]
Rockford, IL 61108 (815) 316-6720[FAX]

Filing Company Information

Pan American Life Insurance Company CoCode: 67539 State of Domicile: Louisiana
1300 Godward Street NE Group Code: Company Type:
Suite 6800
Minneapolis, MN 55413 Group Name: State ID Number:
(612) 331-0112 ext. [Phone] FEIN Number: 72-0281240

SERFF Tracking Number: ICCI-125582305 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan American Life Insurance Company	\$50.00	04/03/2008	19247558

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/21/2008	04/21/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	04/17/2008	04/17/2008	Brenda Dawson	04/21/2008	04/21/2008

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Disposition

Disposition Date: 04/21/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ICCI-125582305 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization Letter (2008)	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Form	Group Dental Policy	Approved-Closed	Yes
Form	Group Dental Certificate	Approved-Closed	Yes
Form	Policyholder Application	Approved-Closed	Yes
Form	Enrollment Application	Approved-Closed	Yes
Form (revised)	Amendatory Endorsement	Approved-Closed	Yes
Form	Amendatory Endorsement	Withdrawn	No
Form (revised)	Amendatory Endorsement	Approved-Closed	Yes
Form	Amendatory Endorsement	Withdrawn	No

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 04/17/2008

Submitted Date 04/17/2008

Respond By Date

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Amendatory Endorsement (Form)

Comment: Our Department's address and phone number is incorrect. Please change to read:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock AR 72201-1904
(800)852-5494 or (501)371-2640

Objection 2

- Amendatory Endorsement (Form)

Comment: Our Department's address and phone number is incorrect. Please change to read:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
(800)852-5494 or (501)371-2640

Objection 3

- Group Dental Certificate (Form)

Comment: Please refer to the Termination of Insurance on Page 21. With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: ICCI-125582305 State: Arkansas
Filing Company: Pan American Life Insurance Company State Tracking Number: 38625
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TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Pan-Am DEN-07-P
Project Name/Number: Pan-Am DEN-07-P/Pan-Am DEN-07-P

Response Letter

Response Letter Status Submitted to State
Response Letter Date 04/21/2008
Submitted Date 04/21/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Hi Rosalind - please find attached revised Amendatory Endorsement DEN-07-P-AE1. We revised the Department's address and phone number as requested.

Also, please find attached revised Amendatory Endorsement DEN-07-C-AE1. We revised the Department's address and phone number and amended the Termination section of the certificate for handicapped dependents.

Your continued review for approval is greatly appreciated. Thank you.

Related Objection 1

Applies To:

- Amendatory Endorsement (Form)

Comment:

Our Department's address and phone number is incorrect. Please change to read:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock AR 72201-1904
(800)852-5494 or (501)371-2640

Related Objection 2

Applies To:

- Amendatory Endorsement (Form)

Comment:

Ou Department's address and phone number is incorrect. Please change to read:

Arkansas Insurance Department
Consumer Services Division

SERFF Tracking Number: ICCI-125582305 State: Arkansas
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1200 West Third Street
 Little Rock, AR 72201-1904
 (800)852-5494 or (501)371-2640

Related Objection 3

Applies To:

- Group Dental Certificate (Form)

Comment:

Please refer to the Termination of Insurance on Page 21. With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Amendatory Endorsement	DEN-07-C-AE1		Certificate Amendment, Insert Page, Endorsement or Rider	Revised		50	AR DEN-07-C-AE1-4-21-08.pdf
Previous Version							
Amendatory Endorsement	DEN-07-C-AE1		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		50	AR DEN-07-C-AE1.pdf
Amendatory Endorsement	DEN-07-P-AE1		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Revised		50	AR DEN-07-P-AE1-4-21-08.pdf
Previous Version							
Amendatory Endorsement	DEN-07-P-AE1		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		50	AR DEN-07-P-AE1.pdf

SERFF Tracking Number: *ICCI-125582305* *State:* *Arkansas*
Filing Company: *Pan American Life Insurance Company* *State Tracking Number:* *38625*
Company Tracking Number: *PAN AM DEN-07-P*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Pan-Am DEN-07-P*
Project Name/Number: *Pan-Am DEN-07-P/Pan-Am DEN-07-P*

No Rate/Rule Schedule items changed.

Sincerely,
Brenda Dawson

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 Filing Company: Pan American Life Insurance Company State Tracking Number: 38625
 Company Tracking Number: PAN AM DEN-07-P
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 Product Name: Pan-Am DEN-07-P
 Project Name/Number: Pan-Am DEN-07-P/Pan-Am DEN-07-P

Form Schedule

Lead Form Number: DEN-07-P

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	DEN-07-P	Policy/Cont ract/Fratern al Certificate	Group Dental Policy	Initial		40	DEN-07-P 2-27-08.pdf
Approved-Closed	DEN-07-C	Certificate	Group Dental Certificate	Initial		40	DEN-07-C - 11-21-07.pdf
Approved-Closed	DEN-07-P-APP	Application/ Enrollment Form	Policyholder Application	Initial		40	DEN-07-P-APP.pdf
Approved-Closed	DEN-07-EN-APP	Application/ Enrollment Form	Enrollment Application	Initial		40	DEN-07-EN-APP.pdf
Approved-Closed	DEN-07-C-AE1	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendatory Endorsement	Revised	Replaced Form #: Previous Filing #:	50	AR DEN-07-C-AE1 4-21-08.pdf
Approved-Closed	DEN-07-P-AE1	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Amendatory Endorsement	Revised	Replaced Form #: Previous Filing #:	50	AR DEN-07-P-AE1 4-21-08.pdf

**PAN-AMERICAN LIFE INSURANCE COMPANY
(A Stock Company)**

PAN-AMERICAN LIFE CENTER, NEW ORLEANS, LOUISIANA 70130

GROUP [DENTAL or DENTAL and VISION or VISION] INSURANCE

**POLICYHOLDER:
POLICY EFFECTIVE DATE:
POLICY ANNIVERSARY DATE:
POLICY NUMBER:
STATE:**

INSURING AGREEMENT

Pan-American Life Insurance Company (We, Our, Us, Company) agrees to pay the benefits provided in this Policy. Benefits will be paid in accordance with the provisions of this Policy for each Insured who is due benefits.

This Policy is issued in consideration of the Policyholder's application and the payment of premiums when due. A copy of the application is attached to and is a part of this Policy.

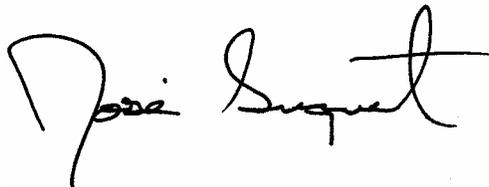
This Policy will take effect on the Date shown above. This Policy's Anniversary will be the Policy Anniversary Date shown above and on the same date in each subsequent year.

This Policy is delivered in and is subject to the laws of the state shown above.

READ THIS POLICY CAREFULLY

In witness whereof, Pan-American Life Insurance Company executes this Policy on the Effective Date shown above.

PAN-AMERICAN LIFE INSURANCE COMPANY



President and Chief Executive Officer

**GROUP [DENTAL or DENTAL and VISION or VISION] POLICY
NONPARTICIPATING**

**PAN-AMERICAN LIFE INSURANCE COMPANY
HOME OFFICE: 601 POYDRAS, NEW ORLEANS, LA 70130
[xxx-xxx-xxxx]**

TABLE OF CONTENTS

	Page
Eligibility	3
Termination of Insurance	4
General Provisions	5

ELIGIBILITY

WHO IS ELIGIBLE?

Insured

An individual will become eligible for coverage under the Policy upon meeting all the following requirements:

1. the individual has submitted a written or electronic request, using a form approved by Us, seeking to apply for coverage under the Policy as an Insured; and
2. the individual is insurable pursuant to Our then current underwriting guidelines[, including any benefit selections or availability based upon age.]
3. the individual is a member or participant in the group to which the Policy is issued.

Dependent Insurance

A Dependent of the Insured will become eligible for coverage under the Policy upon meeting all of the following requirements:

1. the individual meets the definition of Dependent;
2. the Insured has submitted a written or electronic request, using a form approved by Us, seeking to apply for coverage on the individual, under the Policy as a Dependent; and
3. the individual is insurable pursuant to Our then current underwriting guidelines[, including any benefit selections or availability based upon age.]

All evidence that the individual is insurable pursuant to Our current underwriting guidelines shall be provided without expense to Us.

WHEN DOES COVERAGE BEGIN?

[Dental or Dental and Vision or Vision] benefits begin on the effective date which is the first day of the month following enrollment and completion of the Waiting Period shown on the Schedule of Benefits, if any, if:

1. the Insured Person has been enrolled before the first of that month, and
2. We or Our administrator has received the monthly premium payment.

WHEN ARE DEPENDENTS COVERED?

Dependents are covered on the later of:

1. the date Dependent Coverage is first included in Insured's coverage; or
2. the date the person first qualifies as an Insured Dependent.

Newborn Infant Coverage

A Dependent child born while this coverage is in force for an Insured is covered from the moment of birth for Covered [Dental or Dental and Vision or Vision] Expenses. A notice of birth together with the additional premium must be submitted to Us. This must be done within 31 days after the date of birth in order to continue coverage beyond the 31-day period.

Adopted Children Coverage

A Dependent child placed with the Insured for adoption while this coverage is in force shall be covered from the first of the month coinciding with or next following the date of such placement. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement. A notice of placement for adoption together with the additional premium must be submitted to Us. This must be done within 31 days after the date of such placement in order to continue coverage beyond the 31-day period.

TERMINATION OF INSURANCE

The Policyholder may terminate this group policy by sending a written notice to us. The coverage will terminate on the later of:

1. the date requested by the Policyholder; or
2. the date the notice is received.

We may terminate this group Policy on any premium due date. We will give the Policyholder at least sixty (60) days advance written notice of such termination.

The coverage on any Insured will end automatically on the earliest of the following dates:

1. The last day of the month in which the Insured ceases to be eligible for coverage;
2. Subject to the Grace Period provision, the last day of the month for which the required premium has been paid; or
3. The date the Policy is terminated or discontinued.

The coverage of any Dependent will end automatically on the earliest of the following dates:

1. The last day of the month in which the Dependent ceases to be an eligible Dependent;
2. Subject to the Grace Period provision, the last day of the month for which the required premium has been paid; or
3. The date this Policy is terminated or discontinued.

Termination of coverage will not prejudice any existing claim.

GENERAL PROVISIONS

POLICY INCONTESTABLE AFTER ONE YEAR

After this Policy has been in force for one year, We do not have the right to contest its various provisions, except for nonpayment of premiums. After coverage for an Insured has been in force for one year during the Insured's lifetime, We do not have the right to contest the Insured's coverage, except for fraud or nonpayment of premium.

NONPARTICIPATION

This Policy will not share in Our surplus earnings.

LEGAL ACTION

No lawsuit may be brought to recover on this Policy until 60 days after written proof of loss has been given to Us. No lawsuit may be brought more than three years (5 years in Kansas; 6 years in South Carolina; or the applicable statute of limitations in Florida) after proof is required to be filed.

ENTIRE CONTRACT

The Policy, the Certificate of Coverage, application of the Policyholder, the Insured's enrollment cards, and any amendments and endorsements constitute the entire contract. A copy of the application is attached to the Policy. All statements made by the Policyholder, or by an Insured will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim under this Policy, unless it is contained in writing and a copy has been given to the Insured.

MODIFICATION CAN BE MADE ONLY BY AN OFFICIAL

Only Our President, Vice-President, the Secretary or an Assistant Secretary can change or waive any provision of this Policy. Any changes must be made in writing. We will not be bound by any promises or representations made by an agent or anyone other than the above.

TIME EFFECTIVE

This Policy is effective from 12:01 a.m., at the Policyholder's address, on the Policy Effective Date. This Policy shall terminate at 12:01 a.m., at the Policyholder's address, upon the effective date of termination of this Policy.

NEW ENTRANTS

All new eligible employees of the Policyholder and eligible dependents of those employees will become insured when they satisfy the requirements set forth in this Policy.

GENERAL PROVISIONS (Continued)

CERTIFICATES

We will deliver a Certificate of Coverage to the Policyholder for delivery to each applicant who becomes insured under this Policy. The Certificate of Coverage will state the essential features of the Insured's coverage under the group policy.

INFORMATION REQUIRED FROM POLICYHOLDER

The Policyholder must provide Us with the following on a regular basis:

- (1) information about members that may be required to manage a claim; and
- (2) any other information that may be reasonably required.

Policyholder records that have a bearing, in Our opinion, on this Policy will be available for review by Us at any reasonable time as determined by Us.

DUE DATE AND METHOD OF PAYMENT

Premiums are payable on a monthly basis, unless We agree to some other mode of payment. If We agree to change the method of paying premiums, any pro rata adjusted premium required will be payable.

PAYMENT OF PREMIUMS

Premiums are payable at Our Office in New Orleans, LA, or to Our authorized administrator. The first premium for each Insured is due on his/her Effective Date. Each monthly payment will pay for the insurance then in force under the Policy for a period of one month.

GRACE PERIOD

This Policy has a 31-day grace period. If any premium, except the first, is not paid on or before the date it is due, it may be paid during the following 31 days. The coverage remains in force during this grace period. If a premium is not paid by the end of the grace period, Your coverage will terminate as of the last date to which premiums have been paid.

GENERAL PROVISIONS (Continued)

CHANGE IN PREMIUM RATES

Premium rates may be changed at any time if;

- (1) the Policy is amended to change the eligibility provisions and/or benefits; or
- (2) a subsidiary, division or affiliate is added to the Policy.

We may determine that a premium rate change is necessary for reasons other than in (1) or (2) above. However, such a rate change will not be made during the first [12] months beyond the Policy Effective Date or occur more often than once in any 6-month period following the initial [12] month period.

We will provide written notification of any increases in premium rates to the Policyholder at least 45 days prior to the effective date of the increase unless the Policyholder and We both agree otherwise.

Premiums for insurance becoming effective will be charged:

- (1) from the premium due date if it is the same as the Insured Individual's effective date of insurance; or
- (2) from the next premium due date after the Insured Individual's effective date of insurance, if not the same.

The above manner of charging premiums will not extend insurance coverage beyond a date it would have otherwise terminated.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Policy was issued is hereby amended to conform to the minimum requirements of such statutes, unless otherwise forbidden by the laws of the state where the Insured lives.

PAN-AMERICAN LIFE INSURANCE COMPANY

PAN-AMERICAN LIFE CENTER, NEW ORLEANS, LOUISIANA 70130

CERTIFICATE OF INSURANCE

PROVIDING [DENTAL OR DENTAL AND VISION OR VISION] INSURANCE

Group Policy No. [xxxxxxx] (“the Policy”), has been issued to [Policyholder Organization] which we will refer to as “the Policyholder”. We will refer to Pan-American Life Insurance Company as “the Company”, “we”, “us”, “our”.

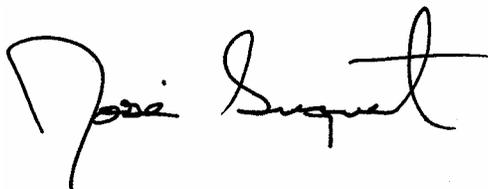
The Policy will be administered on our behalf by “the Administrator” [Administrators Name].

The Policy was delivered in [State] and will be governed by the laws thereof.

This Certificate of Insurance is evidence of the Insured’s insurance under the policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the Policy. The Policy is on file with the Policyholder and may be examined at any reasonable time. Only one of our executive officers can authorize a change of the Policy.

This Certificate replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the Policy.

Signed for Pan-American Life Insurance Company.

A handwritten signature in black ink, appearing to read "Jose Suquet". The signature is written in a cursive style with a horizontal line extending from the end of the name.

President and Chief Executive Officer

**THIS CERTIFICATE IS EVIDENCE OF A CONTRACT
BETWEEN THE POLICY HOLDER AND THE COMPANY
READ IT CAREFULLY**

For service or complaints about the Policy, please address any inquiries to the address shown above or call [1-xxx-xxx-xxxx].

[TABLE OF CONTENTS

	Page
Schedule of Benefits	3
[Dental Benefit]	10
[Vision Benefit]	11
Definitions	12
Eligibility	14
[Dental Exclusions and Limitations].....	15
[Vision Exclusions and Limitations].....	17
Termination of Insurance	18
Extension of Benefits	19
General Provisions	20
Claim Provisions	23

]

[SCHEDULE OF BENEFITS

We will provide the amounts of coverage shown under the Schedule of Benefits for the Insureds and Insured Dependents named on the enrollment application or added pursuant to the Eligibility Section.

[IMPORTANT NOTICE: All benefits are subject to the maximums and other limits shown below. To maximize Your benefits, You should see a Network Dentist. Benefits may be lower if You or an Insured Dependent incur Covered Expenses from a Non-Network Dentist.]

[WAITING PERIOD][Class [I][II][III][IV][V]] [0-30 days]]

[VESTING PERIOD][Class [I][II][III][IV][V]] [30 days]]

[BENEFITS - DENTAL

[CLASS [I] PROCEDURES – PREVENTIVE]

- [[Two] routine (including any initial exam) examinations of mouth and teeth per calendar year.]
- [[Two] prophylaxis (cleaning, scaling and polishing teeth) per calendar year.]
- [[One] topical fluoride per calendar, to age [16].]
- [Bitewing x-rays, limited to [one] series per calendar year.]

[DEDUCTIBLE [AND CO-PAYMENT] – [PREVENTIVE - CLASS [I]]

[[\$10] Deductible per year for You and each of Your insured Dependents [up to [\$30] per family]]
 [[\$10] Co-payment after Deductible has been met]

[PERCENTAGE OF COVERED SERVICES – [PREVENTIVE – CLASS [I]]]

[[Year 1 – 100%], [Year 2 – 100%], and [Year 3 – 100%], of Usual, Customary, and Reasonable Charges.]

[After the Deductible has been met, We will pay the following percentages of Usual, Customary, and Reasonable Charges:

<u>Covered</u>		<u>[Year 1 Benefits]</u>	<u>[Year 2 Benefits]</u>	<u>[Year 3 Benefits]</u>
<u>Services</u>				
		We pay	We pay	We pay
[Preventive]	[Network]	[100%]	[100%]	[100%]
	[Non-Network]	[100%]	[100%]	[100%]

[CLASS [II] PROCEDURES – DIAGNOSTIC]

- [Bitewing x-rays, limited to [one] series per calendar year.]
- [[Two] routine (including any initial exam) examinations of mouth and teeth per calendar year.]
- [[One] diagnostic x-ray, full or panoramic in any [3] year period.]

[DEDUCTIBLE [AND CO-PAYMENT] – [DIAGNOSTIC - CLASS [II]]

[[$\$10$] Deductible per year for You and each of Your Insured Dependents [up to [$\$30$] per family]]
[[$\$10$] Co-payment after Deductible has been met]

[PERCENTAGE OF COVERED SERVICES – [DIAGNOSTIC – CLASS [II]]]

[[Year 1 – 100%], [Year 2 – 100%], and [Year 3 – 100%], of Usual, Customary, and Reasonable Charges.]

[After the Deductible has been met, We will pay the following percentages of Usual, Customary, and Reasonable Charges:

<u>Covered</u>		<u>[Year 1 Benefits]</u>	<u>[Year 2 Benefits]</u>	<u>[Year 3 Benefits]</u>
<u>Services</u>		We pay	We pay	We pay
[Diagnostic]	[Network]	[100%]	[100%]	[100%]
	[Non-Network]	[100%]	[100%]	[100%]

[CLASS [III] PROCEDURES – BASIC]

- [Simple extraction of teeth.]
- [Pin retention of fillings.]
- [Fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations).]
- [Antibiotic injections administered by a dentist.]
- [Space maintainers to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment.]
- [Sealants, one per tooth every [three] years to age [16].]

[DEDUCTIBLE [AND CO-PAYMENT] – [BASIC - CLASS [III]]

[[\$10] per year for You and each of Your insured Dependents [up to [\$30] per family]]
 [[\$10] Co-payment after Deductible has been met]

[PERCENTAGE OF COVERED SERVICES – [BASIC – CLASS [III]]]

[[Year 1 – 80%], [Year 2 – 80%], and [Year 3 – 80%], of Usual, Customary, and Reasonable Charges.]

[After the Deductible has been met, We will pay the following percentages of Usual, Customary, and Reasonable Charges:

<u>Covered Services</u>		<u>[Year 1 Benefits]</u>	<u>[Year 2 Benefits]</u>	<u>[Year 3 Benefits]</u>
		We pay	We pay	We pay
[Basic]	[Network]	[80%]	[80%]	[80%]
	[Non-Network]	[70%]	[70%]	[70%]

[[6] Month Waiting Period]

[[3] Month Vesting Period]

[CLASS [IV] PROCEDURES – MAJOR]

- [[One] diagnostic x-ray, full or panoramic in any [3] year period.]
- [Oral surgery, including postoperative care for:
 - removal of teeth, including impacted teeth;
 - extraction of tooth root;
 - alveolectomy, alveoplasty, and frenectomy;
 - excision of pericoronal gingival, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
 - reimplantation or transplantation of a natural tooth; and
 - excision of a tumor or cyst and incision and drainage of an abscess or cyst.]
- [Endodontic treatment of disease of the tooth, pulp, root, and related tissue, as follows:
 - root canal therapy (not covered, if pulp chamber was opened before covered);
 - pulpotomy;
 - apicoectomy; and
 - retrograde filling.]
- [Periodontic services, limited to:
 - [two] prophylaxis following surgery per calendar year;
 - root scaling and planning, once per quadrant of mouth in any [6] month period;

- occlusal adjustment, performed with covered surgery;
 - gingivectomy, gingival curettage, and mucogingival'
 - osseous surgery including flap entry and closure;
 - pedical or free soft tissue grafts; and
 - one appliance (night guards) in [5-year] period.]
- [One study models in [3-year] period.]
 - [Crown build-up for non-vital teeth.]
 - [Recementing inlays, onlays and crowns;]
 - [One repair of dentures or bridges in any [2-year] period, limited to [20%] of the cost of replacement.]
 - [General anesthesia and analgesic, including intravenous sedation, for oral surgery.]
 - [Restoration services, limited to:
 - Gold or porcelain inlays, onlay, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling material;
 - Replacement of existing inlay, onlay, or crown, after [5] years of the restoration initially placed or last replaced. This limitation will not apply if replacement is necessary due to the extraction of functioning natural teeth while covered;
 - Stainless steel crowns;
 - Post and core.]
 - [Prosthetic services, limited to
 - Initial placement of dentures or fixed bridgework (including acid etch metal bridges), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Policy. This limitation ends after covered under the Policy for [36] months.
 - Replacement of dentures or fixed bridgework that cannot be repaired after [5] years from the date of placed or last placed.
 - Addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Policy. This limitation will not apply after covered under the Policy for [36] months.
 - Relining or rebasing of existing removable dentures, only after [one] year from the date the denture was placed and only once in any [2-year] period.]

[DEDUCTIBLE [AND CO-PAYMENT] – [MAJOR - CLASS [IV]]

[[\$10] Deductible per year for You and each of Your insured Dependents [up to [\$30] per family]]
[[\$10] Co-payment after Deductible has been met]

[PERCENTAGE OF COVERED SERVICES – [MAJOR – CLASS [IV]]]

[[Year 1 – 10%], [Year 2 – 50%], and [Year 3 – 50%], of Usual, Customary, and Reasonable Charges.]

[After the Deductible has been met, We will pay the following percentages of Usual, Customary, and Reasonable Charges:

<u>Covered</u>		<u>[Year 1 Benefits]</u>	<u>[Year 2 Benefits]</u>	<u>[Year 3 Benefits]</u>
<u>Services</u>				
		We pay	We pay	We pay
[Major]	[Network]	[10%]	[50%]	[60%]
	[Non-Network]	[10%]	[40%]	[50%]

[[18] Month Waiting Period]

[DEDUCTIBLE AND [CO-PAYMENT]]

[For Classes [I], [II], [III], and [IV], the Deductible is a combined [\$100] for each family member during their lifetime for Covered Expenses while insured under the Policy [up to [\$300] per family]].

[The first [\$100] of Covered Expenses must be paid for each [Insured][Insured Dependent][Insured and Insured Dependent] during their lifetime for [Endodontics] Covered Expenses while insured under the Policy.]

[[\$10] Co-payment after Deductible has been met]

[ORTHODONTICS

[Limited to dependent children under age [19]]

- [[Surgical therapy.]
- [Appliance therapy.]
- [Functional/myofunctional therapy.]]

[LIFETIME DEDUCTIBLE [AND CO-PAYMENT] – ORTHODONTICS

[[\\$100] Deductible per each Insured Dependent]
 [[\\$10] Co-payment after Deductible has been met]]

[PERCENTAGE OF COVERED SERVICES – ORTHODONTICS]

[[Year 1 – 10%], [Year 2 – 25%], and [Year 3 – 50%], of Usual, Customary, and Reasonable Charges.]

[After the Deductible has been met, We will pay the following percentages of Usual, Customary, and Reasonable Charges:

<u>Covered Services</u>		<u>[Year 1 Benefits]</u>	<u>[Year 2 Benefits]</u>	<u>[Year 3 Benefits]</u>
		We pay	We pay	We pay
[Orthodontics	[Network]	[10%]	[25%]	[50%]
Children under age [19]]	[Non-Network]	[5%]	[15%]	[40%]]

[LIFETIME MAXIMUM BENEFIT – ORTHODONTICS

[\$1,000] per each Insured Dependent]]

CONTRACT YEAR MAXIMUM - DENTAL ONLY

[[\\$1,000] for each Insured and Insured Dependent]

[[\\$500] for each Insured and Insured Dependent for [Endodontics]]]

[BENEFITS - VISION

[Included][Not Included]

	[<u>Network</u>	<u>Non-Network]</u>
[Vision exam		
Deductible	[0;\$5;\$10;\$15]	[0;\$5;\$10;\$15]
Benefit (Limit of one exam during any [12] months in a row.)	[100%]	[100%, up to \$28]

Materials

Deductible [0;\$5;\$10;\$15] [\$0;\$5;\$10;\$15]

Frames Benefit (Limited to one set of frames every [12] months
Up to [\$100.00] Retail [100%] [\$30.00]

Lens Benefit (Uncoated Plastic)

Limited to one set of lenses every [12] months
Lens allowance for a single lens is one half the allowance shown for a pair

Single Vision	[100 %]	[\$20.00]
Bifocal Vision	[100 %]	[\$28.00]
Progressive, No-line Bifocals (\$90 allowance)	[100 %]	[\$32.00]
Trifocal Vision	[100 %]	[\$32.00]
Lenticular Vision	[100 %]	[\$32.00]

Contact Lenses

Limited to one pair of contact lenses every [12] months.)

Medically Necessary	Up to [\$200.00] Retail	[100 %]	[\$55.00]
Cosmetic	Up to [\$100.00] Retail	[100 %]	[\$55.00]

Covered Person is responsible for any separate contact lens professional fitting fee not covered by the contact lens allowance.

Spectacle lens styles, materials, treatments or “add-ons” not shown in the above Schedule will be an additional cost to the insured, based on an agreement, if any, with the Provider Network.]

[COMPREHENSIVE VISION EXAMINATION

One exam in first [twenty four (24) month] period and once each [twelve (12) months] thereafter -
[\$50] maximum benefit after the Insured’s or Insured Dependent’s Effective Date.
[\$20] Deductible Per Year/Per Family Member

LENSES AND FRAMES

Single Vision, Bifocal, or Trifocal lenses, including Progressive lenses; and frames up to [\$100] per frame - one set of lenses and frames in any one [twenty-four month] benefit period
[\$50] Deductible Per Year/Per Each Insured and Insured Dependent
[24] Month Waiting Period

[TAKEOVER BENEFITS]

[NONE]

[If the Insured or Insured Dependent was covered under a Prior Policy on the day before the effective date of coverage under the Policy, We will credit the time the Insured was covered by the Prior Policy against the Policy's Waiting Period. For the purposes of this provision, "**Prior Policy**" means the Insured's dental insurance plan(s) in effect the day before the Policy Effective Date.]

[POLICY YEAR MAXIMUM - [DENTAL or DENTAL AND VISION or VISION]

[Dental or Dental and Vision or Vision] For each Insured and Insured Dependent:

[\$1,500]

]

[DENTAL BENEFIT

WHAT ARE ELIGIBLE EXPENSES?

We will pay You the Benefits stated in the Schedule of Benefits when We have received proof that Covered Expenses have been incurred by You or an Insured Dependent. Covered Expenses must be incurred while the Policy is in force and the Insured or Insured Dependent is covered by the Policy.

For You to be eligible for reimbursement under the Policy, the Dental service must be performed by a Dentist.

[WHEN ARE THE BENEFITS PRE-AUTHORIZED?

Preauthorization of Benefits is a review by Us of a Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. This review should be made whenever Dental work is proposed that exceeds [\$300.00]. The information should be sent to Us before the Dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to Us. Preauthorization of Benefits does not guarantee payment.]

WHEN WILL AN ALTERNATE BENEFIT BE PROVIDED?

If:

1. We determine that a less expensive alternate procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and
2. the alternative treatment will produce a professionally satisfactory result, then the maximum We will allow will be the charge for the less expensive treatment.

WHEN ARE BENEFITS PAID?

A Covered Expense is considered incurred on the following dates:

1. For full and partial dentures - on the date the final impression is taken.
2. For fixed bridges, crowns, inlays and onlays - on the date the teeth are first prepared.
3. For root canal therapy - on the date the pulp chamber is opened.
4. For periodontal surgery - on the date surgery is performed.
5. For all other services - on the date the service is performed.]

[VISION BENEFIT

We will only pay this benefit if it is shown as included in the Schedule of Benefits.

We will pay the Vision Benefits stated in the Schedule of Benefits when We have received proof that expenses for Vision Benefits, subject to any Limitations or Exclusions, have been incurred by an Insured. Expenses for Vision Benefits must be incurred while the Policy is in force and the Insured or Insured Dependent is covered by the Policy.

Vision Materials Benefit:

If the Vision Examination covered by the Policy results in the Insured or Insured Dependent needing corrective Vision Material for their visual health and welfare, that Vision Material prescribed will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

Lens--Up to two lenses provided one time in each successive Benefit period.

Frame--One frame provided one time in each successive Benefit period.]

DEFINITIONS

[[**“ADA Code”** means the American Dental Association Code assigned to a particular Dental procedure.]

“Benefit” means the specific benefit for each particular [Dental or Dental and Vision or Vision] procedure shown in the Schedule of Benefits.

“Copayment” means the dollar amount that You are required to pay at the time dental services are provided.]

“Covered Expense(s)” means an expense for [Dental or Dental and Vision or Vision] procedures shown in the Schedule of Benefits.

“Deductible” means an amount of Covered Expense incurred by an Insured or Insured Dependent while covered by the Policy which must be paid by an Insured before Our responsibility to pay benefits for any expenses begins. The Deductible amount is shown on the Schedule of Benefits.

“Dentist” means:

1. A licensed dentist who is acting within the scope of his or her license;
2. A licensed physician performing Dental services within the scope of his or her license; or
3. A licensed Dental hygienist acting under the supervision and direction of a dentist.]

“Dependent”/“Insured Dependent” means any of the following persons:

1. The Insured's spouse;
2. Each unmarried child of the Insured from birth to age [21];
3. Each unmarried child of the Insured who is a full-time student until age [24] provided such child is attending an accredited college, vocational or high school and enrolled in sufficient courses to maintain full-time status and is dependent on the Insured listed on the face page for their support and maintenance. We may require proof of full-time status.
4. Each unmarried child of the Insured at least [21] years of age:
 - a) who is incapable of self-sustaining employment by reason of mental or physical handicap;
 - b) who was so incapacitated and is an Insured Dependent under the Policy on his or her [21st] birthday; and
 - c) who has been continuously so incapacitated since his or her [21st] birthday.

“Geographic Area” means the first three digits of the zip code in which the service, treatment, procedure, drugs or supplies are provided, or a greater area if necessary, to obtain a representative cross-section of charges for a like treatment, service, procedure, device, drug or supply

“Insured’s Effective Date” means the first day of the month following the Insured’s enrollment and completion of the Waiting Period shown on the Schedule of Benefits, if any.

DEFINITIONS (Continued)

"Insured", "You", "Your", "Yours" means the individual who has: (a) submitted an application for coverage on himself or herself, his or her Dependents, or both; (b) meets the eligibility and effective date provisions set forth in the Policy; (c) is approved for coverage by Us; and (d) for whom all applicable premiums are paid.

["Network Dentist" means a Dentist who has entered into a written agreement with a preferred provider organization that We have contracted with to provide dental services.]

["Non-Network Dentist" means a Dentist who has not entered into a written agreement with a preferred provider organization that We have contracted with.]

"Policy" means the Group Policy issued to the Policyholder.

"Policyholder" means the entity to which the Policy is issued.

"Policy Year Maximum" means the maximum amount payable by Us for all Covered Expenses in any period of 365 consecutive days. The Policy Year Maximum will apply to each Insured and Insured Dependent.

"Usual, Customary, and Reasonable" means a charge that does not exceed the general level of charges being made by other providers of [Dental or Dental and Vision or Vision] services in the Geographic Area where the charge is incurred. [With respect to Network Dentists, this is the contracted fee schedule amount.]

[Network Vision Provider - means an optometrist, ophthalmologist, optician or optical supply business that has entered into a written agreement with a preferred provider organization that we have contracted with and has agreed to provide vision care services and supplies.]

[Non-Network Vision Provider - An optometrist, ophthalmologist, optician or optical supply business that has not entered into a written agreement with a preferred provider organization that we have contracted with to provide vision care services or supplies.]

["Vision Benefit" means the specific benefit for Vision Examinations and Vision Materials as shown in the Schedule of Benefits. For You to be eligible for reimbursement under the Policy, the Vision service must be performed by:

1. a licensed Optometrist who is acting within the scope of his or her license;
2. a licensed Ophthalmologist who is acting within the scope of his or her license;
3. a licensed dispensing Optician who is acting within the scope of his or her license.]

["Vision Examination" means a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.]

["Vision Materials" means corrective lenses and frames.]

DEFINITIONS (Continued)

["Vesting Period"] is a period of continuous coverage for an Insured under the Policy, starting on the most recent Insured's Effective Date, during which expenses for certain classes of services are not covered. The lengths of all Vesting Periods, and the classes of service to which they apply, are shown on the Schedule of Benefits.]

["Waiting Period"] is a period of time that must pass before an Insured or Insured Dependent is eligible to be covered for benefits under the Policy. The lengths of all Waiting Periods and the classes of service to which they apply, are shown on the Schedule of Benefits.]

“We”, “Our”, “Us”, “Company” means Pan-American Life Insurance Company.]

ELIGIBILITY

WHO IS ELIGIBLE?

Insured

An individual will become eligible for coverage under the Policy upon meeting all the following requirements:

1. the individual has submitted a written or electronic request, using a form approved by Us, seeking to apply for coverage under the Policy as an Insured; and
2. the individual is insurable pursuant to Our then current underwriting guidelines[, including any benefit selections or availability based upon age.]
3. the individual is a member or participant in the group to which the Policy is issued.

Dependent Insurance

A Dependent of the Insured will become eligible for coverage under the Policy upon meeting all of the following requirements:

1. the individual meets the definition of Dependent;
2. the Insured has submitted a written or electronic request, using a form approved by Us, seeking to apply for coverage on the individual, under the Policy as a Dependent; and
3. the individual is insurable pursuant to Our then current underwriting guidelines[, including any benefit selections or availability based upon age.]

All evidence that the individual is insurable pursuant to Our current underwriting guidelines shall be provided without expense to Us.

WHEN DOES COVERAGE BEGIN?

[Dental or Dental and Vision or Vision] benefits begin on the Insured's Effective Date following completion of the Waiting Period shown on the Schedule of Benefits, if any, if:

1. We approve his or her written request for coverage., and
2. We or Our administrator has received the monthly premium payment.

WHEN ARE DEPENDENTS COVERED?

The Policy becomes effective for an Insured Dependent on the date on which We approve the Insured's written request for coverage for the Dependent and the applicable premium is paid.

Newborn Infant Coverage:

A Dependent child born while coverage is in force for an Insured is covered from the moment of birth for Covered Expenses. A notice of birth together with the additional premium must be submitted to Us. This must be done within 31 days after the date of birth in order to continue coverage beyond the 31-day period.

ELIGIBILITY
(Continued)

Adopted Children Coverage:

A Dependent child placed with You for adoption while coverage is in force shall be covered from the date of such placement. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement. A notice of placement for adoption together with the additional premium must be submitted to Us. This must be done within 31 days after the date of such placement in order to continue coverage beyond the 31-day period.

[DENTAL EXCLUSIONS AND LIMITATIONS

COVERED DENTAL EXPENSES WILL NOT INCLUDE AND NO BENEFITS WILL BE PAYABLE:

1. [for charges in excess of those considered Usual, Customary and Reasonable;]
2. [for overdentures and associated procedures;]
3. [for replacement of retainers;]
4. [for athletic mouthguards;]
5. [for denture duplication;]
6. [for acid etch;]
7. [for broken appointments;]
8. [for prescription or take-home fluoride;]
9. [for diagnostic photographs;]
10. [for any treatment which is for cosmetic purposes, or to correct congenital malformations. Facings on crowns or pontics beyond the second bicuspid are considered cosmetic, except for medically necessary care and treatment of cleft lip and palate;]
11. [to replace any: prosthetic appliance; crown; inlay; or restoration; or fixed bridge that can be repaired or restored to normal function. But if a replacement is required because of an accidental bodily injury sustained while the Insured or Insured Dependent is covered under the Policy, it will be a Covered Expense;]
12. [for initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of one or more natural teeth while the Insured or Insured Dependent is covered under the Policy. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth;]
13. [for any procedure begun before the Insured or Insured Dependent was covered under the Policy;]
14. [for any procedure begun after the Insured's or Insured Dependent's insurance under the Policy terminates, or for any prosthetic Dental appliance installed or delivered more than 90 days after the Insured's or Insured Dependent's insurance under the Policy terminates;]
15. [to replace lost or stolen appliances;]
16. [for appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion;
 - c. splint or replace tooth structure lost as a result of abrasion or attrition; or

**[DENTAL EXCLUSIONS AND LIMITATIONS
(Continued)**

- d. treat disturbances of the temporomandibular joint.]
- 17. [for any procedure which is not shown on the Schedule of Benefits;]
- 18. [for education or training in, and supplies used for: dietary or nutritional counseling; personal oral hygiene; or Dental plaque control;]
- 19. [for the completion of claim forms;]
- 20. [for any treatments or supplies for sealants and fluoride application;]
- 21. [for subgingival curettage or root planing unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved;]
- 22. [because of an injury arising out of, or in the course of, work for wage or profit.]
- 23. [to an Insured or Insured Dependent because of a sickness, injury or condition for which he or she is eligible for benefits under any Workers' Compensation act or similar laws;]
- 24. [for charges for which the Insured is not liable or which would not have been made had no insurance been in force;]
- 25. [for services which are not recommended by a dentist or which are not required for necessary care and treatment;]
- 26. [because of war or any act of war, declared or not, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;]
- 27. [for any services related to: equilibration; bite registration; or bite analysis;]
- 28. [for crowns for the purpose of periodontal splinting;]
- 29. [for charges for: any implants; precision or semi-precision attachments; and any endodontic treatment associated with it; other customized attachments;]
- 30. [for any Dental injury or condition that is intentionally self-inflicted;]
- 31. [for charges that are applied toward satisfaction of a Deductible, if any;]
- 32. [for charges that are generally considered by the dental profession as experimental;]
- 33. [for hospital services;]
- 34. [for orthodontia.]
- 35. [for treatment received outside the United States, its territories, or possessions.]]

[VISION EXCLUSIONS AND LIMITATIONS

No benefits will be paid for service or material connected with or charges arising from:

1. [Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;]
2. [Medical and/or surgical treatment of the eye, eyes, or supporting structures;]
3. [Any eye or Vision Examination or any corrective eyewear, required by an employer as a condition of employment;]
4. [Services provided as a result of any Worker's Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, State, or subdivisions thereof;]
5. [Plain (non-prescription) lenses;]
6. [Prescription sun glasses;]
7. [Glasses secured when there is no prescription change;]
8. [Two pair of glasses in lieu of bifocals;]
9. [Any coatings applied to lenses or frames;]
10. [Contact lenses of any kind;]
11. [Services or materials not shown in the Schedule of Benefits.]
12. [Lost or broken lenses, frames, or glasses will not be replaced except in the next Benefit period when Vision Material would next become available.]
13. Aniseikonic lenses]

TERMINATION OF INSURANCE

The Policyholder may terminate the Policy by sending a written notice to Us. The coverage will terminate on the later of:

1. the date requested by the Policyholder; or
2. the date the notice is received.

We may terminate the Policy on any premium due date. We will give the Policyholder at least sixty (60) days advance written notice of such termination.

The coverage on the Insured will end automatically on the earliest of the following dates:

- [[1. The last day of the month next following the Insured's [65th] birthday];
2. The next premium due date after We receive Your request to terminate coverage of the Insured under the Policy;
3. Subject to the Grace Period provision, the last day of the month for which the required premium has been paid; or
- 4.] The date the Policy is terminated or discontinued.

The coverage of any Dependent will end automatically on the earliest of the following dates:

1. The last day of the month in which the Dependent ceases to be an eligible Dependent;
2. the next premium due date after we receive Your written requires to terminate coverage of the Dependent under the Policy;
3. Subject to the Grace Period provision, the last day of the month for which the required premium has been paid; or
4. The date the Policy is terminated or discontinued.

Termination of coverage will not prejudice any existing claim.

The attainment of the limiting age by a covered Dependent will not cause coverage to terminate while that person is and continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and Chiefly Dependent on You for support and maintenance.

“Chiefly Dependent” means the covered Dependent receives the majority of his/her financial support from You. If a covered Dependent is handicapped beyond the limiting age and You desire continued coverage for Your covered Dependent, You must provide written proof that the covered Dependent is Chiefly Dependent, at least thirty-one (31) days prior to the date upon which the covered Dependent would otherwise reach the limiting age. Thereafter, We may request such proof no more frequently than annually. In the absence of such proof, We may terminate the coverage of such person after the attainment of the limiting age.

[EXTENSION OF BENEFITS

After dental coverage terminates, We will continue to pay for Covered Expenses for the procedures listed below, if:

1. treatment began prior to termination; and
2. the work is completed within [31] days after termination. [For Orthodontics, We will continue to pay scheduled benefits through the end of the month in which coverage terminated.]

Treatment is deemed completed as follows:

1. for fixed bridges including resin bonded bridges, crowns, inlays, onlays and other laboratory fabricated restorations: on the date that the appliance is permanently cemented in place; and
2. for root canal therapy: on the date the canals are permanently filled; and
3. for dentures and partial dentures: on the date that the final completed appliance is first inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.

If You or Your Insured Dependents become eligible for dental coverage that will pay any benefits for treatment covered by this provision, We will not pay any benefits for that treatment.

This provision does not apply if Your coverage terminates because You send Us notice of termination or fail to pay the required premium when due.]

GENERAL PROVISIONS

NETWORK PROVIDER SERVICES

Network provider services and supplies are available to all Insured Persons through any preferred provider organization that we have contracted with to provide [dental][vision] services.

Should an Insured Person use the services or supplies of a Network [Vision][Dental]Provider, the Network benefit payment rate shown in the Schedule of Benefits will apply.

Should an Insured Person use the services or supplies of a Non-Network [Vision][Dental]Provider, the Non-Network benefit payment rate shown in the Schedule of Benefits will apply.

COORDINATION OF BENEFITS

If any individual covered under the Policy (referred to as "**this Plan**") is also covered under one or more other Plans, the benefits payable under this Plan will be coordinated with the benefits payable under all other Plans.

This coordination will apply in determining the benefits payable for any Claim Period if the sum of:

1. the benefits that would be payable under this Plan in the absence of coordination; and
2. the benefits that would be payable under all other Plans in the absence of provisions for coordination in those Plans would exceed those Covered Expenses.

Except as provided in the following paragraph, when Coordination of Benefits applies to the benefits payable to an individual for any Claim Period, the benefits that would be payable for Covered Expenses under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Covered Expenses under all other Plans will not exceed the total of those Covered Expenses. Benefits payable under all other Plans include the benefits that would have been payable had claim been properly made for them.

The rules establishing the order of benefit determination are:

1. the benefits of a Plan which covers the individual for whom claim is made other than as a Dependent will be determined before the benefits of a Plan which covers that individual as a Dependent.
2. Except as stated in paragraph 3 below, when this Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
 - a) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later that year; but
 - b) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described in (a) immediately above, but instead uses a different method, and if, as a result, the Plans do not

GENERAL PROVISIONS

(Continued)

agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a) First, the Plan of the parent with custody of the child;
 - b) Then, the Plan of the spouse of the parent with custody of the child; and
 - c) Finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of that Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
4. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (4) is ignored.
5. If none of the above rules determines the order of benefits, the benefits of a Plan which has covered the individual for whom claim is made for the longer period of time will be determined before the benefits of a Plan which has covered the individual the shorter period of time.

If We are responsible for secondary coverage for Covered Expenses, We will not deny coverage or payment of the amount We owe as secondary payor solely on the basis of the failure of another group contract, which is responsible for primary coverage, to pay for those Covered Expenses. This will not require Us to pay the obligations of the primary payor.

For the purpose of administering the above provisions of this Plan or any similar provision of other Plans, We may, without consent or notice to any individual, release to or obtain from any other insurance company, organization or individual any information concerning any individual which We consider necessary. Any individual claiming benefits under this Plan will furnish Us with any information necessary.

Whenever payment which should have been made under this Plan in accordance with the above provisions have been made under any other Plans, We will have the right, at Our sole discretion, to pay any organizations making these payments any amount We determine to be due. Amount paid in this matter will be considered to be benefits paid under this Plan and, to the extent of these payments, We will be fully discharged from liability under this Plan.

**GENERAL PROVISIONS
(Continued)**

Whenever payments have been made by Us, for Covered Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, We will have the

right to recover the excess from one or more of the following: (1) other insurance companies; (2) other organizations; (3) individuals to or from whom payments were made.

BENEFITS SUBJECT TO COORDINATION. All benefits provided under the Policy are subject to coordination.

DEFINITIONS. The following definitions apply only to this Coordination of Benefits section.

1. The term "Plan" means coverage providing hospital, medical or [Dental or Dental and Vision or Vision] benefits or services by:
 - a) group or blanket insurance coverage, except school accident coverage;
 - b) group practice or other prepayment coverage on a group basis; or
 - c) any coverage under labor-management trusteed Plan, union welfare Plan, employer organization, or employee benefit Plans.

The term "Plan" will be construed separately for a Policy, contract or other arrangement for benefits or services that reserves the right to take the benefits or services of other Plans into consideration in determining its benefits, or separately for that portion which does not reserve the right.

2. The term "Covered Expense" means any usual, reasonable and customary item of expense all or part of which is covered under one of the Plans.

When a Plan provides benefits in the forms of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both a Covered Expense and a benefit paid.

3. The term "Claim Period" means a calendar year or a portion of a calendar year for a claim on an individual covered under this Plan.

POLICY INCONTESTABLE AFTER ONE YEAR

After the Policy has been in force for one year, We do not have the right to contest its various provisions, except for fraud or nonpayment of premium. After coverage for an Insured or Insured Dependent has been in force for one year during the Insured or Insured Dependent's lifetime, We do not have the right to contest the Insured or Insured Dependent's coverage, except for fraud or nonpayment of premium.

NONPARTICIPATION

The Policy will not share in Our surplus earnings.

GENERAL PROVISIONS (Continued)

LEGAL ACTION

No lawsuit may be brought to recover on the Policy until 60 days after written proof of loss has been given to Us. No lawsuit may be brought more than three years [(5 years in Kansas; 6 years in South Carolina; or the applicable statute of limitations in Florida)] after proof is required to be filed.

ENTIRE CONTRACT

The Policy, application of the Policyholder, the Insured's enrollment application, and any amendments and endorsements thereto constitute the entire contract. A copy of the application is attached to Your Certificate. All statements made by an Insured will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim under the Policy, unless it is contained in writing and a copy has been given to the Insured.

MODIFICATION CAN BE MADE ONLY BY AN OFFICIAL

Only Our President, Vice-President, the Secretary or an Assistant Secretary can change or waive any provision of the Policy. Any changes must be made in writing. We will not be bound by any promises or representations made by an agent or anyone other than the above.

TIME EFFECTIVE

The Policy is effective from 12:01 a.m., at the Policyholder's address, on the Policy Effective Date. The Policy shall terminate at 12:01 a.m., at the Policyholder's address, upon the effective date of termination of the Policy.

DUE DATE AND METHOD OF PAYMENT

Premiums are payable on a monthly basis, unless We agree to some other mode of payment. If We agree to change the method of paying premiums, any pro rata adjusted premium required will be payable.

PAYMENT OF PREMIUMS

Premiums are payable at Our Office in New Orleans, LA, or to Our authorized administrator, or representative. The first premium for each Insured is due on his/her Insured's Effective Date. Each monthly payment will pay for the insurance then in force under the Policy for a period of one month.

GRACE PERIOD

Coverage under the Policy has a 31-day Grace Period. If any premium, except the first, is not paid on or before the date it is due, it may be paid during the following 31 days. The coverage remains in force during this Grace Period. If a premium is not paid by the end of the Grace Period, Your coverage will terminate as of the last date to which premiums have been paid.

GENERAL PROVISIONS (Continued)

CHANGE IN PREMIUM RATES

We reserve the right to change premiums, [on a class basis,] on any premium due date.

[However, such a rate change will not be made during the first [12] months beyond the Policy Effective Date or occur more often than once in any 6-month period following the initial [12] month period.]

We will provide written notification of any increases in premium rates to the Insured at least [31] days prior to the effective date of the increase.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Policy was issued is hereby amended to conform to the minimum requirements of such statutes, unless otherwise forbidden by the laws of the state where the Insured lives.

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be given within 30 days from the date of treatment or service was rendered or as soon as reasonably possible. The notice can be given to Us at Our office in New Orleans, LA or to Our agent. Notice should include sufficient information to identify the Insured and Insured Dependent.

CLAIM FORMS

When We have received the notice of claim, We will send the forms for filing proof of loss. If these forms are not sent within 15 days, the claimant will meet the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.

A claim form may be obtained from Us during normal business hours. The instructions on the claim form should be followed carefully and all questions should be completely answered.

PROOFS OF LOSS

Written proof of loss must be given to Us within 90 days from the date the treatment or service was rendered. If it was not possible to give written proof in the time required, We will not deny the claim for this reason if the proof is filed as soon as reasonably possible. However, proof of loss must be submitted within one year from the date written proof of loss was due.

PHYSICAL EXAMINATION

While a claim is pending, We reserve the right to examine, as often as We may reasonably require, the person whose condition is the basis of the claim. Any such examination will be at Our expense.

TIME PAYMENT OF CLAIMS

We will pay immediately, or within 30 days following receipt of due written proof of loss, all benefits due under the Policy.

PAYMENT OF CLAIMS

Benefits will be paid to the Insured [unless assigned to the provider]. Any accrued benefits unpaid at the Insured's death will be paid to the Insured's estate.

APPLICATION FOR GROUP [DENTAL or DENTAL AND VISION or VISION] INSURANCE

The [ABC Group] hereby requests to insure eligible persons under Policy DEN-07-P, based upon its statements and representations that follow. [The [ABC Group] must select the coverage and pay the required premium.] Those eligible will be covered as described in this application. It is agreed that this application supersedes any previous application for this Group [Dental or Dental and Vision or Vision] Insurance.

[Association] Name: _____

Address: _____ City: _____ State: _____ Zip: _____

[Phone number: (_____) _____] [Direct Communications To: _____]
(Name and Title)

[Fax number: (_____) _____] [Contact e-mail address: _____]

[Subsidiaries and Affiliates Included: Yes No Affiliate Name(s): _____]

PROVISION AND BENEFIT SELECTION

[Effective Date Requested: _____ (not sooner than the first day of the first month following acceptance by the Company).]

Coverage Options*:

- 5+ Orthodontia, if available in your state (\$3.17, employee. \$6.06, employee +1. \$10.17, family)
- 5+ Endo/Perio covered under Class II (premium x 1.10)
- \$50 annual deductible for Class II & III (premium x 1.12)

Coverage Options*:

- 5+ Orthodontia, if available in your state (\$3.17, employee. \$6.06, employee +1. \$10.17, family)
- 5+ Endo/Perio covered under Class II (premium x 1.10)
- \$50 annual deductible for Class II & III (premium x 1.12)
- Takeover Benefits]

[* Premiums must be adjusted accordingly]

BEFORE YOU SIGN, PLEASE SEE THE BACK OF THIS DOCUMENT FOR IMPORTANT FRAUD NOTICES

Authorized Signature for [Association]: _____ Date: _____
Name: _____ Title: _____

[Agent's Signature: _____ Date: _____]
Name: _____ State License #: _____

Underwritten by: PAN-AMERICAN LIFE INSURANCE COMPANY, NEW ORLEANS, LA

[IMPORTANT FRAUD NOTICES]

[FRAUD STATEMENT]
Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or 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 is a crime and subjects such person to criminal and civil penalties.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA
Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA
Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KENTUCKY
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.
FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF 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.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA
WARNING: 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.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS
Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE
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.
FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

[IMPORTANT NOTICE: HIV TESTING]

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.]

PAN-AMERICAN LIFE INSURANCE COMPANY
New Orleans, Louisiana

[Product Name] [Dental/Vision] Insurance Enrollment Application Form

Enrollment Information (PLEASE PRINT CLEARLY)

Last Name	First Name	Initial	Birth Date ____/____/____	Marital Status
Address	Telephone Number		Sex M [] F []	Married [] Single []
City		State	Zip	

[FAMILY INFORMATION (List only those eligible family members who are enrolling)]

[Last Name (If Different) Spouse [Domestic Partner]	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Dependent					
Dependent					
Dependent]					

[COVERAGE SELECTION:]* [Dental/Vision] [PPO] Coverage

I apply for coverage on: [Applicant Only Applicant + One Applicant and Family]

[1. Does Spouse [Domestic Partner] have a dental Plan: Yes No With Whom? _____]

If answer is "Yes", are dependents enrolled under spouses [Domestic Partner] plan? Yes No

[2. Do you claim a tax exemption for all eligible dependents listed above? Yes No

If no, who is not? _____]

[3. All dependent children listed above over age 18 are full-time students. Yes No

*[Your insurance coverage is subject to an agreement with a Preferred Provider Organization ("PPO") or your level of benefits may be reduced. It is important that you verify that your dentist or optometrist or other service provider is a part of our PPO each time you make an appointment or at the time of service.]

I hereby request coverage under the group policy issued to [the Association] and underwritten by Pan American Life Insurance Company.

I agree that (a) I am responsible for making the proper monthly premium payments; and (b) a grace period of 31 days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the 31 days grace period, coverage for all insured persons shall lapse as of the premium due date.

I have personally reviewed all of my answers to the questions on this enrollment application and any attachments to it and certify that all of the information I have provided is true, complete and correct. I agree that under no circumstances is any agent allowed to: (a) waive, alter or modify any questions; or (b) permit me to inaccurately answer any question. I agree that no agent is authorized or has the authority to alter the terms of the Policy.

DO NOT CANCEL ANY EXISTING DENTAL INSURANCE UNTIL RECEIVING WRITTEN NOTICE OF APPROVAL.

By my signature below, I hereby apply for the coverage or coverages selected above. [I CERTIFY THAT I HAVE READ THE APPLICABLE FRAUD NOTICE ON THE REVERSE SIDE.] I understand that this enrollment application shall not be altered in any way unless I have given written consent.

[Applicant Signature _____ Date _____]

FOR COMPANY USE ONLY

Effective Date: ____/____/____ Plan Code: _____

Division _____ CPT: _____

Mail To:
[Licensed Producer]

Administered by:
[Licensed TPA]

[FRAUD STATEMENT

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

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA

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

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KENTUCKY

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.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA

WARNING: 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE

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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

PAN-AMERICAN LIFE INSURANCE COMPANY

GROUP DENTAL CERTIFICATE OF INSURANCE AMENDATORY ENDORSEMENT

AMENDATORY ENDORSEMENT NO. 1

ATTACHED TO AND MADE A PART OF **CERTIFICATE NO. DEN-07-C**

This Amendatory Endorsement applies only to coverage provided under the Certificate to an Insured who is a resident of Arkansas at the time of application for this coverage. The Certificate is amended, as of the Effective Date of Your Policy, as follows:

1. The COVER PAGE is amended to include the following NOTICE:

NOTICE

Should you have any questions with your coverage, you should contact your agent identified on your Application;
or you may contact our policyholder service office at:

Pan-American Life Insurance Company
601 Poydras, New Orleans, Louisiana 70130
(877) 569-3075

Furthermore, you may also obtain assistance through the:

Arkansas Insurance Department
Consumer Service Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: (800) 852-5494 or (501) 371-2640

2. The **ELIGIBILITY** Section is amended by the deletion of the **Adopted Children Coverage** section. The following is substituted in its place:

Adopted Children Coverage

A Dependent child for whom You have filed a petition to adopt while this coverage is in force will be covered on the date of the filing of a petition for adoption if You enroll for coverage and provide any additional premium within 60 days after the filing of the petition for adoption. However, the coverage will begin from the moment of birth if the petition for adoption and enrollment together with any additional premium is submitted to Us within sixty (60) days after the birth of the minor. This coverage will continue, unless the petition for adoption is dismissed or denied.

3. The **TERMINATION OF INSURANCE** Section the 7th paragraph pertaining to "Chiefly Dependent" means the covered Dependent receives the majority of his/her financial support from You, has been deleted and replaced with the following:

"Chiefly Dependent" means the covered Dependent receives the majority of his/her financial support from You. If a covered Dependent is handicapped beyond the limiting age and You desire continued coverage for Your covered Dependent, You must provide written proof that the covered Dependent is Chiefly Dependent prior to the date upon which the covered Dependent would otherwise reach the limiting age. Thereafter, We may request such proof no more frequently than annually. In the absence of such proof, We may terminate the coverage of such person after the attainment of the limiting age.

Except as amended above, the Certificate remains unchanged. All changes are subject to the terms and conditions of the Certificate.

PAN-AMERICAN LIFE INSURANCE COMPANY



President and Chief Executive Officer

PAN-AMERICAN LIFE INSURANCE COMPANY
GROUP DENTAL POLICY AMENDATORY ENDORSEMENT

AMENDATORY ENDORSEMENT NO. 1

ATTACHED TO AND MADE A PART OF **POLICY NO. DEN-07-P**

This Amendatory Endorsement applies only to coverage provided under the Policy to an Insured who is a resident of Arkansas at the time of application for this coverage.

The Policy is amended, as of the Effective Date of Your Policy, as follows:

1. The COVER PAGE is amended to include the following NOTICE:

NOTICE

Should you have any questions with your coverage, you should contact your agent identified on your Application;
or you may contact our policyholder service office at:

Pan-American Life Insurance Company
601 Poydras, New Orleans, Louisiana 70130
(877) 569-3075

Furthermore, you may also obtain assistance through the:

Arkansas Insurance Department
Consumer Service Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: (800) 852-5494 or (501) 371-2640

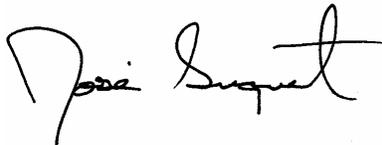
2. The ELIGIBILITY Section is amended by the deletion of the Adopted Children Coverage section. The following is substituted in its place:

Adopted Children Coverage

A Dependent child for whom You have filed a petition to adopt while this coverage is in force will be covered on the date of the filing of a petition for adoption if You enroll for coverage and provide any additional premium within 60 days after the filing of the petition for adoption. However, the coverage will begin from the moment of birth if the petition for adoption and enrollment together with any additional premium is submitted to Us within sixty (60) days after the birth of the minor. This coverage will continue, unless the petition for adoption is dismissed or denied.

Except as amended above, the Policy remains unchanged. All changes are subject to the terms and conditions of the Policy.

PAN-AMERICAN LIFE INSURANCE COMPANY



President and Chief Executive Officer

SERFF Tracking Number: *ICCI-125582305* *State:* *Arkansas*
Filing Company: *Pan American Life Insurance Company* *State Tracking Number:* *38625*
Company Tracking Number: *PAN AM DEN-07-P*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Pan-Am DEN-07-P*
Project Name/Number: *Pan-Am DEN-07-P/Pan-Am DEN-07-P*

Rate Information

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>ICCI-125582305</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>38625</i>
<i>Company Tracking Number:</i>	<i>PAN AM DEN-07-P</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Pan-Am DEN-07-P</i>		
<i>Project Name/Number:</i>	<i>Pan-Am DEN-07-P/Pan-Am DEN-07-P</i>		

Supporting Document Schedules

Satisfied -Name:	Certification/Notice	Review Status:	Approved-Closed	04/21/2008
Comments:				
Attachments:				
	AR_Fee_Schedule DEN-07.pdf			
	Cert of Comp DEN-07.pdf			
Satisfied -Name:	Application	Review Status:	Approved-Closed	04/21/2008
Comments:				
	Application is part of the form filing			
Satisfied -Name:	Authorization Letter (2008)	Review Status:	Approved-Closed	04/21/2008
Comments:				
Attachment:				
	ICC PAN-AM AUTH - Dental plan 07 (2008).pdf			
Satisfied -Name:	Cover letter	Review Status:	Approved-Closed	04/21/2008
Comments:				
Attachment:				
	AR Pan Amer DEN-07.pdf			



ARKANSAS INSURANCE DEPARTMENT

1200 West Third Street
Little Rock Arkansas 72201-1904
501-371-2600

Mike Pickens
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: Pan-American Life Insurance Company
Company NAIC Code: 67539
Company Contact Person & Telephone #: Brenda Dawson, Insurance Compliance Consultants, Inc., (815) 316-6714
Form Number(s): DEN-07-P, DEN-07-C, DEN-07-P-AE1, DEN-07-C-AE1, DEN-07-P-APP, DEN-07-EN-APP

* INSURANCE DEPARTMENT USE ONLY *
* ANALYST: AMOUNT: ROUTE SLIP: *

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing *1 x \$50 = \$50 **Retaliatory
Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer. * x \$50 = **Retaliatory
Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form. * x \$20 = **Retaliatory
Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms. * x \$20 = **Retaliatory
Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer. * x \$25 = **Retaliatory

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to
amend an Insurer's Certificate of Authority.

* _____ x \$400 = _____

Filing to amend Certificate of Authority.

*** _____ x \$100 = _____

*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE
AND REGULATION 57.

**THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK.
CODE ANN. 23-63-102, RETALIATORY TAX.

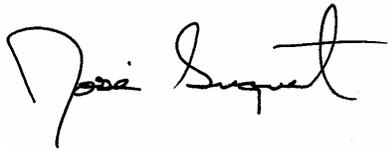
***THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. 23-61-401.

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Pan-American Life Insurance Company

Form Number(s): DEN-07-P, et.al.,

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.

A handwritten signature in black ink that reads "Jose Suquet". The signature is written in a cursive style with a large initial "J" and a long horizontal stroke at the end.

Signature of Company Officer

Jose Suquet

Name

President and CEO

Title

April 3, 2008

Date



January 1, 2008

NAIC Company Code: 67539

Re: Dental Policy form DEN-07-P, et.al.,

To: All State Insurance Departments

Pan-American Life Insurance Company of New Orleans, LA, hereby authorizes Insurance Compliance Consultants, Inc., to represent us in the submission of the above captioned forms and to negotiate with insurance departments for their approval.

Sincerely,

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink that reads "José Suquet". The signature is written in a cursive style with a long horizontal stroke at the end.

José Suquet, President and Chief Executive Officer



INSURANCE
COMPLIANCE
CONSULTANTS, INC.

519 Colman Center Drive
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 316-6720

April 3, 2008

Honorable Julie Benafield Bowman
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: Pan-American Life Insurance Company – NAIC: 67539 FEIN: 72-0281240
Group [Dental or Dental and Vision or Vision] Policy – DEN-07-P
Certificate of Insurance – DEN-07-C
Amendatory Endorsement No. 1 – DEN-07-P-AE1
Amendatory Endorsement No. 1 – DEN-07-C-AE1
Policyholder Application – DEN-07-P-APP
Enrollment Application – DEN-07-EN-APP

Dear Commissioner Benafield Bowman:

We are hereby submitting the above referenced forms for filing in your state. These forms are new and are not intended to replace any forms previously approved in your state.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Pan-American Life Insurance Company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

Group [Dental or Dental and Vision or Vision] Policy form DEN-07-P may be issued to groups that meet the appropriate statutory eligibility requirements of your state, as well as groups located outside of your state. Form DEN-07-C is the Certificate of Insurance evidencing coverage under the Group Policy. Amendatory Endorsement form DEN-07-P-AE1 will be attached to the Group Policy and Amendatory Endorsement DEN-07-C-AE1 will be attached to all Certificates issued in Arkansas.

Application form DEN-07-EN-APP is the application used to apply for coverage and Application DEN-07-P-APP is the group application.

Bracketed material is considered variable.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

The Policy document was prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the actual text of the contract or to the general print size.

Your prompt review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at (815)316-6714, fax me at (815)316-6720, or e-mail me at Brendadawson@inscompliance.com . Thank you.

Sincerely,

Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.