12th District Dental Program
HOW TO ENROLL-(Standard Option)

1. Complete in full the Safeguard application. (Personal Information, Benefit/Dependent Information, and sign the Authorization section)
2. Select a dentist by going to the Safeguard website: www.safeguard.net Enter the provider number on the enrollment form in the Benefit/Dependent section. (You may call Safeguard at 1-800-880-1800 to be sure that the dentist you're selecting is still open to enrollment and accepting new patients.)
3. Sign and date the form at the bottom in the section marked AUTHORIZATION.
4. You may pay premiums via a biweekly allotment, a monthly discretionary allotment, or semiannually by personal check.
5. If you will be paying for coverage by payroll deduction, complete the 1199A payroll deduction form (Section 1- Parts A, C, G and Signature; Section 2 Agency Name and Payroll Address). . Remember that you are only allowed two allotments according to many agency regulations; so make sure you have an allotment open. Note that many federal agencies now require employees to initiate the payroll deduction process electronically. If your agency requires this please refer to the Direct Deposit Form for the Bank Routing Number (Section 3) and the Account Number (Section 1, Part E). In either case, you will then need to mail the completed 1199A along with your completed application.

HOW MUCH DOES THE STANDARD OPTION COST?

Coverage	Bi-Weekly Payroll Allotment	Discretionary Allotment (Monthly)	Semi-Annual Check
Single	$ 7.00	$ 15.17	$ 91.00
Single +1	$ 13.00	$ 28.17	$ 169.00
Family	$ 18.00	$ 39.00	$ 234.00

Mail your completed application and a **copy** of the Payroll Deduction Form 1199A or a check for your first semi-annual period to:

Benefit Architects Administrators
Attn: 12th District Dental Plan
1256 Main Street, Suite 249
Southlake, TX 76092

(Please note the original 1199A must be turned in to your payroll center if you did not initiate the payroll deduction electronically)

WHEN AM I ELIGIBLE?*

Benefit Architects must receive one monthly discretionary, or two (2) bi-weekly payroll deductions for payment by the 15th of the month for eligibility to begin the first of the following month. The dental plan will send new member packets after the reporting period is completed on the 20th of the month. After the 20th of the month, you may call Customer Service at 1-800-880-1800 to check benefits, change providers or request ID cards.

If at any time you have a change of address, telephone number, or a change in dependent coverage, please advise Benefit Architects Administrators. If you are on leave without pay, (Workers Comp, Extended Sick Leave, Military Service, etc.) you will be responsible for paying the premiums until your allotments begin again.

QUESTIONS? Email: janis_conner@BenefitArchitects.com or call 1-800-733-7236, Ext. 16

SafeGuard® SCHEDULE OF BENEFITS

DENTAL PLAN SG185

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each service. There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations. We have also added some dental terminology definitions to help you better understand your plan - these can be found at the back of this Schedule.

Code	Service	Co-payment
Diagnostic Treatment		
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D9491	Office visit fee - per visit	$5
D0210	X-rays intraoral - complete series - including bitewings (once every 3 years)	$0
D0220	X-rays intraoral - periapical - first film	$0
D0230	X-rays intraoral - periapical - each additional film	$0
D0240	X-rays intraoral - occlusal film	$0
D0250	X-rays extraoral - first film	$0
D0260	X-rays extraoral - each additional film	$0
D0270	X-rays bitewing - single film	$0
D0272	X-rays bitewings - two films	$0
D0274	X-rays bitewings - four films	$0
D0330	X-rays panoramic film	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
Preventive Services		
Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.		
D1110	Prophylaxis - adult*	$0
D1120	Prophylaxis - child*	$0
D1201	Topical application of fluoride (including prophylaxis) - child*	$0
D1203	Topical application of fluoride (excluding prophylaxis) - child*	$0
D1204	Topical application of fluoride (excluding prophylaxis) - adult*	$0
D1205	Topical application of fluoride (including prophylaxis) - adult*	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant- per tooth	$5
D1510	Space maintainer - fixed - unilateral	$25
D1515	Space maintainer - fixed - bilateral	$25
D1520	Space maintainer - removable - unilateral	$35
D1525	Space maintainer - removable - bilateral	$35
D1550	Recementation of space maintainer	$5
Restorative Treatment		
D2140	Amalgam - one surface, primary or permanent	$10
D2150	Amalgam - two surfaces, primary or permanent	$15
D2160	Amalgam - three surfaces, primary or permanent	$18
D2161	Amalgam - four or more surfaces, primary or permanent	$20
D2330	Resin-based composite - one surface, anterior	$15
D2331	Resin-based composite - two surfaces, anterior	$20

Code	Service	Co-payment
D2332	Resin-based composite - three surfaces, anterior	$30
D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	$35
D2390	Resin-based composite crown, anterior	$35
D2391	Resin-based composite, one surface, posterior	$65
D2392	Resin-based composite, two surfaces, posterior	$75
D2393	Resin-based composite, three surfaces, posterior	$80
D2394	Resin-based composite, four or more surfaces, posterior	$80
Crowns		
• *Replacement Limit 1 every 5 years.*		
• *Procedures identified by two asterisks (**) involve the additional cost of noble/ high noble metal.*		
• *Cases involving 7 or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.*		
• *$75 fee per crown unit above co-pay for porcelain on molars.*		
D2510	Inlay - metallic - one surface**	$165
D2520	Inlay - metallic - two surfaces**	$165
D2530	Inlay - metallic - three or more surfaces**	$165
D2543	Onlay - metallic - three surfaces**	$185
D2544	Onlay - metallic - four or more surfaces**	$185
D2740	Crown - porcelain/ceramic substrate	$225
D2750	Crown - porcelain fused to high noble metal**	$185
D2751	Crown - porcelain fused to predominantly base metal	$185
D2752	Crown - porcelain fused to noble metal**	$185
D2780	Crown - 3/4 cast high noble metal**	$185
D2781	Crown - 3/4 cast predominantly base metal	$185
D2782	Crown - 3/4 cast noble metal**	$185
D2790	Crown - full cast high noble metal**	$185
D2791	Crown - full cast predominantly base metal	$185
D2792	Crown - full cast noble metal**	$185
D2910	Recement inlay	$0
D2920	Recement crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$25
D2931	Prefabricated stainless steel crown - permanent tooth	$25
D2940	Sedative filling	$0
D2950	Core build up, including any pins	$50
D2951	Pin retention - per tooth, in addition to restoration	$10
D2952	Cast post and core in addition to crown	$50
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal (not in conjunction with endodontic therapy)	$10
Endodontics		
All procedures exclude final restoration		
D3110	Pulp cap - direct	$0
D3120	Pulp cap - indirect	$0
D3220	Therapeutic pulpotomy	$10
D3230	Pulpal therapy with resorbable filling - primary anterior tooth	$30
D3240	Pulpal therapy with resorbable filling - primary posterior tooth	$35
D3310	Root canal - anterior, per tooth	$105
D3320	Root canal - bicuspid, per tooth	$115
D3330	Root canal - molar, per tooth	$265
D3346	Retreatment of root canal - anterior, per tooth	$135

Code	Service	Co-payment
D3347	Retreatment of root canal - bicuspid, per tooth	$175
D3348	Retreatment of root canal - molar, per tooth	$275
D3351	Apexification/recalcification - initial visit	$65
D3352	Apexification/recalcification - interim visit	$65
D3353	Apexification/recalcification - final visit	$65
D3410	Apicoectomy/periradicular surgery - anterior	$180
D3421	Apicoectomy/periradicular surgery - bicuspid, 1st root	$180
D3425	Apicoectomy/periradicular surgery - molar, 1st root	$180
D3426	Apicoectomy/periradicular surgery - each additional root	$180
D3430	Retrograde filling - per root	$180
D3450	Root amputation - per root	$95
D3920	Hemisection - including root removal (excluding root canal therapy)	$90
Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces - per quadrant	$90
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	$68
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$250
D4241	Gingival flap procedure, including root planing - one to three teeth - per quadrant	$188
D4249	Clinical crown lengthening - hard tissue	$125
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces - per quadrant	$300
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	$225
D4270	Pedicle soft tissue graft procedure	$250
D4271	Free soft tissue graft procedure (including donor site surgery)	$250
D4273	Subepithelial connective tissue graft procedure	$300
D4274	Distal or proximal wedge procedure - separate procedure	$70
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$50
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$38
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized site - specific therapy	$60
D4910	Periodontal maintenance procedures - following active therapy (2 in a 12 month period)	$50
Removable Prosthodontics		
	• *Replacement Limit 1 Every 5 years.*	
	• *Procedures identified with three asterisks (***) are limited to 1 every 24 months.*	
	• *Includes up to 3 adjustments within 6 months of delivery.*	
D5110	Complete upper denture	$210
D5120	Complete lower denture	$210
D5130	Immediate upper denture	$225
D5140	Immediate lower denture	$225
D5211	Upper partial - resin base (including clasps, rests and teeth)	$300
D5212	Lower partial - resin base (including clasps, rests and teeth)	$300
D5213	Upper partial - cast metal base with resin saddles (including clasps, rests and teeth)	$300
D5214	Lower partial - cast metal base with resin saddles (including clasps, rests and teeth)	$300
D5410	Adjust complete denture - upper	$0

Code	Service	Co-payment
D5411	Adjust complete denture - lower	$0
D5421	Adjust partial denture - upper	$0
D5422	Adjust partial denture - lower	$0
D5510	Repair broken complete denture base	$30
D5520	Replace missing or broken teeth	$30
D5610	Repair resin denture base	$30
D5620	Repair cast framework	$45
D5630	Repair or replace broken clasp	$35
D5640	Replace broken teeth - per tooth	$30
D5650	Add tooth to existing partial denture	$30
D5660	Add clasp to existing partial denture	$45
D5710	Rebase complete upper denture	$75
D5711	Rebase complete lower denture	$75
D5720	Rebase upper partial denture	$75
D5721	Rebase lower partial denture	$75
D5730	Reline complete upper denture (chairside)***	$50
D5731	Reline complete lower denture (chairside)***	$50
D5740	Reline upper partial denture (chairside)***	$50
D5741	Reline lower partial denture (chairside)***	$50
D5750	Reline complete upper denture (laboratory)***	$65
D5751	Reline complete lower denture (laboratory)***	$65
D5760	Reline upper partial denture (laboratory)***	$65
D5761	Reline lower partial denture (laboratory)***	$65
D5820	Interim partial denture - upper	$75
D5821	Interim partial denture - lower	$75
D5850	Tissue conditioning - upper	$10
D5851	Tissue conditioning - lower	$10
Crowns/Fixed Bridges - Per Unit		
	• *Replacement Limit 1 every 5 years.*	
	• *Procedures identified by two asterisks (**) involve the additional cost of noble/ high noble metal.*	
	• *Cases involving 7 or more crowns and/or fixed bridge units in the same treatment plan require additional $125 member fee per unit in addition to co-pay.*	
	• *$75 fee per crown/bridge unit above co-pay for porcelain on molars.*	
D6210	Pontic - cast high noble metal**	$185
D6211	Pontic - cast predominantly base metal	$185
D6212	Pontic - cast noble metal**	$185
D6240	Pontic - porcelain fused to high noble metal**	$185
D6241	Pontic - porcelain fused to predominantly base metal	$185
D6242	Pontic - porcelain fused to noble metal**	$185
D6750	Crown - porcelain fused to high noble metal**	$185
D6751	Crown - porcelain fused to predominantly base metal	$185
D6752	Crown - porcelain fused to noble metal**	$185
D6780	Crown - 3/4 cast high noble metal**	$185
D6781	Crown - 3/4 cast predominantly base metal	$185
D6782	Crown - 3/4 cast noble metal**	$185
D6790	Crown - full cast high noble metal**	$185
D6791	Crown - full cast predominantly base metal	$185
D6792	Crown - full cast noble metal**	$185
D6930	Recement bridge	$0
D6970	Cast post and core in addition to bridge retainer	$50
D6971	Cast post as part of bridge retainer	$30
D6972	Prefabricated post and core in addition to bridge retainer	$30
D6973	Core build up for retainer, including any pins	$10

Code	Service	Co-payment
Oral Surgery		
• *Includes routine post operative visits/treatment.*		
• *Surgical removal of impacted teeth not covered unless pathology (disease) exists.*		
• *Surgical removal of wisdom tooth/third molar for orthodontic reasons only is not covered.*		
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical removal of erupted tooth	$50
D7220	Extraction - removal of impacted tooth - soft tissue	$75
D7230	Extraction - removal of impacted tooth - partially bony	$100
D7240	Extraction - removal of impacted tooth - completely bony	$125
D7241	Extraction - removal of impacted tooth - completely bony, with unusual surgical complications	$130
D7250	Surgical extraction - removal of residual tooth roots	$75
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110
D7280	Surgical exposure of impacted unerupted tooth for orthodontic reasons	$200
D7285	Biopsy of oral tissue - hard	$0
D7286	Biopsy of oral tissue - soft	$0
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$35
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$40
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$40
D7971	Excision of pericoronal gingiva	$25
Orthodontics		
Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.		
D8020	Limited orthodontic treatment of the transitional dentition	$725
D8030	Limited orthodontic treatment of the adolescent dentition	$725
D8040	Limited orthodontic treatment of the adult dentition	$725
D8070	Comprehensive orthodontic treatment of the transitional dentition (full treatment case - including fixed/removable appliances)	$1695
D8080	Comprehensive orthodontic treatment of the adolescent dentition (full treatment case - including fixed/removable appliances)	$1695
D8090	Comprehensive orthodontic treatment of the adult dentition (full treatment case - including fixed/removable appliances)	$1695
D8660	Consultation	$0
D8680	Retention phase (including fee for fixed/removable retainers and monthly visits for 24 months)	$250
D8999	Orthodontic treatment plan and records (pre/post x-rays, photos, study models)	$250
Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9215	Local anesthesia	$0
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$0
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$35
D9630	Medicinal application/irrigation per visit	$15
D9951	Occlusal adjustment - limited	$15
D9952	Occlusal adjustment - complete	$50
D9999	Broken appointment (less than 24-hour notice)	$20

Dental Terminology Definitions

These definitions are designed to give you a "layman's understanding" of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam: A silver filling

Anterior: Teeth that are in the front of the mouth

Bicuspid: Most people have four bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.

Bridge: A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).

Crown: A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.

Endodontics: Procedures that treat disease and injury to the inside of the tooth (the nerve or pulp).

Oral Surgery: Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.

Orthodontics: Braces and other procedures to straighten the teeth.

Periodontics: Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).

Posterior: Teeth that set towards the back of the mouth.

Primary Teeth: The first set of teeth ("baby" teeth).

Prophylaxis: Teeth cleaning

Prosthodontics: Procedures related to the replacement of teeth with removable appliances like dentures or partial dentures.

Quadrant: One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).

Resin-based Composite: Tooth-colored (white) fillings

SG185-SOB Member Services (800) 880-1800 5/03

Exclusions and Limitations

Exclusions

1. Services performed by a general dentist or dentist whose practice is limited to providing Specialty Care, not contracted with SafeGuard without prior approval by SafeGuard, (except for out of area emergency services).
2. Any dental services, or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the SafeGuard Selected General Dentist.
3. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
4. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.
5. Orthognathic surgery.
6. General anesthesia or intravenous sedation.
7. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
8. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.
9. Treatment of malignancies, cysts, or neoplasms.
10. Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
11. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
12. Precision attachments.
13. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
14. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
15. Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war.
16. Services considered unnecessary or experimental in nature.
17. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.
18. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member including, but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.
19. Dental services relating to injuries which are self-inflicted.

Limitations

1. Procedures identified by * are limited to twice a year unless medically necessary.
2. Procedures identified by ** involve the additional cost of noble/high noble metal.
3. Procedures identified by *** are limited to one every twenty four (24) months.

Exclusions and Limitations

4. Full-mouth X-rays: Once every three (3) years unless medically necessary.
5. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a SafeGuard Benefit Plan. Replacements will be a benefit only if the existing denture is unsatisfactory and can not be made satisfactory as determined by the SafeGuard contracted general dentist.
6. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption.
7. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
8. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.
9. There is a $75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
10. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit.
11. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
12. Surgical removal of impacted teeth is not a covered benefit unless pathology [disease] exists.
13. The co-payments listed for endodontic procedures do not include the cost of final restoration.

Orthodontic Exclusions & Limitations

1. Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or contracted dentist whose practice is limited to providing Specialty Care in order for the co-payments listed in the Schedule of Benefits to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of $25 dollars.
3. The following are not included as orthodontic benefits:
   - A. Repair or replacement of lost or broken appliances;
   - B. Retreatment of orthodontic cases;
   - C. Treatment in progress at inception of eligibility;
   - D. Interceptive or Phase I orthodontics;
   - E. Changes in treatment necessitated by an accident;
   - F. Treatment involving:
     1.) Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
     2.) Hormonal imbalances or other factors affecting growth or developmental abnormalities;
     3.) Treatment related to temporomandibular joint disorders;
     4.) Lingually placed direct bonded appliances and arch wires ("invisible braces"); and
     5.) Functional appliances that are used in conjunction with fixed appliances.
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

EL's 2.1

SG185-SOB Member Services (800) 880-1800 5/03

AFGE
SafeGuard Dental HMO Enrollment Form — California

Please print clearly when completing the Enrollment Form and return it to your Union Local or Fax to Benefit Architects at 866.722.1604. Choose a general dental office (facility) of your choice for each eligible family member from the SafeGuard Directory of Participating Dentists. Failure to do so may result in delays in receiving dental care. If your first provider facility selection is not available, SafeGuard will process your second selection.

Union Local/Benefit Architects Use Only

Group/Employer Name	Group No.	Effective Date	Date of Hire
AFGE			

Union Local No.	Agent Signature	Agent No.

Check one:

☐ **SG185 (Standard Option)**	☐ **PV20 (High Option)**

Subscriber's Information

Last Name	First Name	MI	Subscriber SS# - -

Home Address	Apt. #

City	State	Zip Code

Male/Female	Date of Birth	Home Telephone ( )	Work Telephone ( )	Ext.

1st Choice Dental Office #	**2nd Choice Dental Office #**

Dependent Information

Spouse/ Child	Male/ Female	Last Name	First Name	MI	Date of Birth	Student Y/N	Disability Y/N	**1st Choice Dental Office #**	**2nd Choice Dental Office #**

Primary language: _____ **Please note any communication impairment:** _____

Agreement - I understand that any dispute or controversy which may arise between SafeGuard and my Organization or between myself and SafeGuard Health Plans, Inc., must be submitted to binding arbitration in lieu of a jury or court trial. This may not apply in all states.

Authorization to release dental records - I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all dental records which pertain to me or any member of my family, maintained by my chosen Selected General Dentist and/or Specialist, to SafeGuard and/or any designated agent or representative for the purposes of dental treatment, care and for SafeGuard's quality assessment and utilization reviews, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

Waiver of Coverage

I have been given the opportunity to apply for group dental insurance, but:

☐ Do not choose to elect this coverage.

Visit our website at www.safeguard.net for up-to-date provider listings.

Your Name (Please Print)	Your Signature	Date

Standard Form 1199A
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for direct deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER
SS#

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER
2 3 6 1 5 6 8 9 4

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☐ Other Savings Allotment *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT
(Standard Option) Allotment	

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

Frost National Bank
PO Box 1600
San Antonio, TX 78296-1600

ROUTING NUMBER 1 1 4 0 0 0 0 9 CHECK DIGIT 3

DEPOSITOR ACCOUNT TITLE
12th District Dental

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENRATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE
Jeremy Whalon		(949) 251-4156	07/01/2004

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.