

Easy To Enroll!

- To enroll simply fill out an application.
- Everyone is eligible, however, dependents must meet dependent status. (Children up to 19 and full-time students up to 23 are eligible dependents.)

Member Services

Have a question?

Call 1-800-290-0523 between 8:00 a.m. and 5:30

p.m. CST, Monday through Friday, and one of our friendly and professional Representatives will help you. Upon request, they will create a personalized listing of the Providers closest to you.

Quality Assurance

Only The Best!

Our Providers go through an extensive credentialing process to ensure that you are receiving the highest quality dental care.

Renewal Policy

Welcome Back!

The length of the dental plan is for a minimum of one year and automatically renews unless the Member notifies CAREINGTON in writing.

Mail completed application to:

St Louis Benefits Group
504 Water Street
Fenton, MO 63026
p – 636.349.0401
f – 636.349.0402

GET QUALITY DENTAL CARE AT AFFORDABLE RATES!



HIGHLIGHTS OF THE DENTAL NETWORK

INCLUDES:

Pre-existing Conditions Accepted

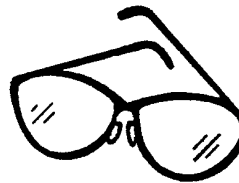
No Claim Forms

No Deductibles

No Waiting Periods

Unlimited Use of the Plan

Routine Orthodontics Covered



Vision Care Coverage Is Included

Only Six Steps!

Please complete the following application.

- | | | |
|---------------------------------|--------------------------|-------------------------------|
| 1. SELECT COVERAGE | 2. FILL OUT YOUR NAME | 3. COMPLETE YOUR ADDRESS |
| 4. LIST COVERED DEPENDENTS ONLY | 5. CHOOSE PAYMENT METHOD | 6. SIGN AND MAIL WITH PAYMENT |

I would like to cover (check one):

- Myself only \$6.95
 Me and one dependent \$11.95
 My whole family \$15.95

Name _____ Social Security Number _____ Spouse's Name _____

Home Address (Incl. Apt. #) _____ City _____ St _____ Zip _____ Home Phone (incl. AC) _____

List of Dependents to Cover	1. Name _____	Birthday (/ /) _____	2. Name _____	Birthday (/ /) _____	3. Name _____	Birthday (/ /) _____
	4. Name _____	Birthday (/ /) _____	5. Name _____	Birthday (/ /) _____	6. Name _____	Birthday (/ /) _____

<input type="checkbox"/> I want to pay MONTHLY by BANK DRAFT. I hereby authorize you to pay checks drawn on my account by CAREINGTON International, and payable to same provided there are sufficient collected funds in said account to pay the same upon presentation. Enclose a voided check AND a check for first month's premium payable to CAREINGTON International.	Individual	\$ 6.95	1st Month + \$15.00 one-time application fee	TOTAL DUE \$21.95 \$28.95 \$30.95
	Individual + 1 Family Rate	\$11.95 \$15.95		

I want to pay by CHECK or MONEY ORDER payable to CAREINGTON International on a:			Payment Calculation To pay by Check or Credit Card: Take amount from table on left, and add one-time \$15.00 application fee.
<input type="checkbox"/> Quarterly Basis – enclose premium payments for 3 months with application.	Individual	Qtrly. \$ 20.85 Annual \$83.40 Individual + 1 \$ 35.85 \$143.40 Family Rate \$ 47.85 \$191.40	
<input type="checkbox"/> Annual Basis – enclose premium payments for 12 month with application			

I want to pay by CREDIT CARD on a:
 Quarterly Basis
 Annual Basis
 Account Number _____

Visa
 MasterCard
 American Express
 Discover
 Name on Card _____
 Exp. Date _____

Subscriber's Signature X _____ Date _____

I understand the terms and conditions of the plan and I hereby adopt the plan for a minimum of one year.

For QBI Use Only	Member No.	Group No. DEMQBI-	GA QUALBE	Agent MBARTZ	Effective Date
------------------	------------	-------------------	-----------	--------------	----------------