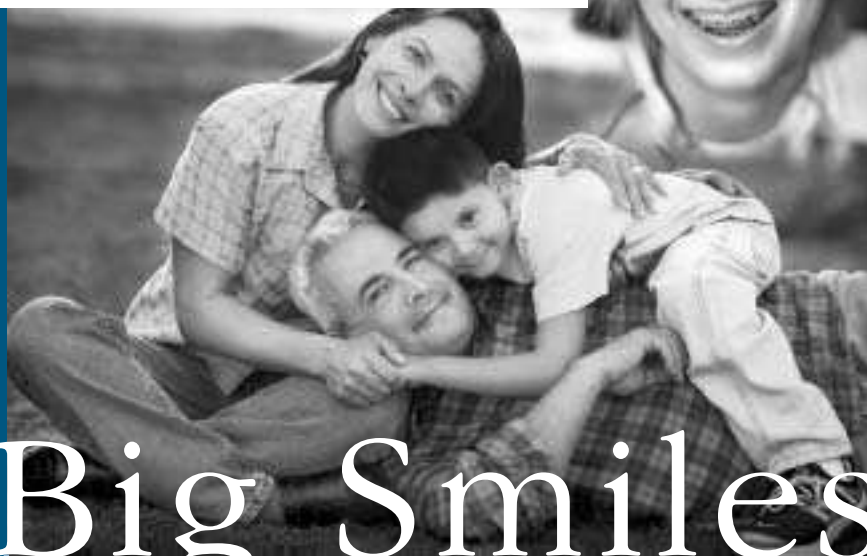


Small Change



Dental and Vision



Big Smiles

PacifiCare
SignatureSavingsSM
Savings through select providers



Start Saving. *Enroll Today!*

An affordable alternative to insurance, PacifiCare SignatureSavings was designed to offer you access to PacifiCare's network of dental and vision providers at a *savings of up to 50%*. There are many reasons why this may be a great alternative for you:

- If you are among the millions of Americans with no dental or vision coverage
- If your employer offers medical coverage only
- If you have opted out of dental and/or vision benefit coverage for personal or financial reasons
- If you are, or have a family member that is, a student not covered by dental or vision benefits
- If you are self-employed or are temporarily on COBRA
- If you have dental and/or vision insurance coverage and are looking for savings on treatments not included in your benefits (for example, cosmetic services)

Here are some advantages to joining the PacifiCare SignatureSavings program:

- No waiting period, age restrictions, claim forms, deductibles or annual maximums
- Include everyone in the household for just \$10.95 per month (single rate is \$8.95 per month)
- Cosmetic and traditional services available
- Access to a large network of dental and vision providers

Monthly Program Costs:

Individual	\$8.95
Family	\$10.95
<i>Plus a one-time \$15 enrollment fee</i>	

After enrolling, simply contact the participating provider of your choice and schedule an appointment. You may receive a listing of participating providers by calling toll-free 1-888-581-8577 from 6 A.M. to 5 P.M. Pacific time, Monday through Friday. Or visit our Web site at www.signaturesavings.net.

When setting up an appointment, inform your selected provider that you are a participant in the PacifiCare SignatureSavings program. Upon arrival at your appointment, present your card and identify yourself as a PacifiCare SignatureSavings participant. You will pay the provider directly for services received.

What materials will I receive once I enroll in the plan?

You will receive a welcome letter, ID card, sample fee schedule, and a listing of providers in your neighborhood.

What's the minimum and maximum age to join the plan?

There are no age limitations.

If I have enrolled for family participation, does everyone have to go to the same dentist?

No, each participant in your family may see a different participating provider.

What if I need to change my individual participation to family participation?

Contact customer service toll-free at 1-888-581-8577, or visit our Web site at www.signaturesavings.net.

Who do I call if I have a question?

Call toll-free 1-888-581-8577 to speak to a Customer Service representative, Monday through Friday, 6 A.M. to 5 P.M. Pacific time.

www.signaturesavings.net

PacifiCare
SignatureSavings
...an affordable
alternative
to insurance.





Dental.

PacifiCare SignatureSavings is designed for health-conscious consumers that are looking to maintain their oral health and to minimize their dental care expenses. Save money on routine care such as cleanings, examinations and X-rays, and on the following specialty treatments:

- Periodontal treatment
- Fillings and extractions
- Root canals
- Crowns and bridges
- Dentures
- Orthodontics for both children and adults
- Cosmetic dentistry

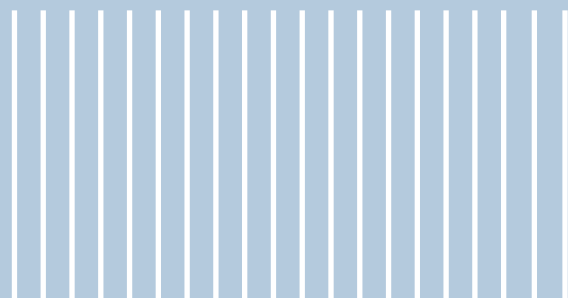
Examples of savings:¹

<i>Procedure</i>	<i>Usual Fee²</i>	<i>You Pay</i>	<i>Savings</i>
Exam	\$49	\$14	\$35
Adult Cleaning	\$86	\$56	\$30
Child Cleaning	\$59	\$34	\$25
Full-Mouth X-Rays	\$140	\$63	\$77
Porcelain Crown	\$902	\$604	\$298
Upper Denture	\$1,157	\$456	\$701
Orthodontics	\$4,500	\$3,300	\$1,200
Teeth Whitening	\$323	\$134	\$189

¹ For ZIP code 92704.

² Usual fee is an average based on the 80th percentile of the Medicare Fee Schedule calculated per geographical region.

For savings in your area, please call toll-free 1-888-581-8577.
Visit our Web site at www.signaturesavings.net.





Vision.

PacifiCare SignatureSavings offers its participants savings on eyeglasses, contact lenses and lens options through PacifiCare's large network of provider locations. In addition, participants may receive discounts on eye examinations and procedures such as LASIK. There is no limit to the number of eyewear purchases under the program, for you or your family. Sunglasses may also be purchased at a discounted price.

How to obtain vision discounts

Select a participating provider near you. You can visit your nearest participating provider at:

- Sears Optical
- Pearle Vision
- JCPenney Optical
- Target Optical

Or choose from hundreds of independent optometrists on our list of participating providers.

Fixed-Fee Discount Schedule:

Frames

	<i>You Pay</i>
Priced up to \$60 retail	\$25
Priced from \$61 to \$80 retail	\$35
Priced from \$81 to \$100 retail	\$45
Priced over \$100 retail	35% discount from retail

Lenses (Standard Uncoated Plastic)

	<i>You Pay</i>
Single Vision	\$30
Bifocal	\$50
Trifocal	\$60

Lens Options

	<i>You Pay</i>
Standard Progressive (no-line bifocal)	\$50
Polycarbonate	\$30
Scratch-Resistant Coating	\$12

Eye Examination

	<i>You Pay</i>
Eyeglasses	\$40 (\$45 in Oklahoma)
Contact Lenses	\$10 off retail price

Contact Lenses

Visit our participating providers and save 20% from retail prices and 10% off of disposable-lens prices.

Use the Contacts Direct™ program by calling 1-800-987-5367.

Laser Vision Correction

PacifiCare SignatureSavings also offers discounts to participants interested in LASIK — a laser vision correction procedure. Participants can receive substantial savings when utilizing the LASIK network. For additional information regarding LASIK, call 1-888-705-2020, Monday through Friday.

Terms and Conditions:

THIS IS NOT INSURANCE

PacifiCare SignatureSavingsSM is offered by PacifiCare Dental and Vision Administrators, a division of PacifiCare Health Plan Administrators, Inc. **PacifiCare SignatureSavings is a discount access program and not an insurance or managed care dental or vision product.** PacifiCare SignatureSavings does not underwrite or accept risk and does not cover or pay for services. Participants are responsible for decisions regarding the services they receive and for monitoring the quality and appropriateness of those services. Participants must select from the PacifiCare SignatureSavings panel of dental and vision providers to obtain discounted services. Participation in the program begins upon enrollment.

Participants are responsible for paying providers directly for services obtained. The fees charged and discounts given by panel providers to PacifiCare SignatureSavings participants vary by geographic location. Please check with dental or vision providers on the panel for discounted rates charged to PacifiCare SignatureSavings participants. Providers, discounts and the availability of PacifiCare SignatureSavings are subject to change.

Customer Service:

For updated listings of panel providers and complete terms and conditions, please call our Customer Service department toll-free at 1-888-581-8577 or visit our Web site at www.signaturesavings.net.



**PACIFICARE SIGNATURESAVINGS
LC05-342
P.O. BOX 25187
SANTA ANA, CA 92799-5187**

PacifiCare
SignatureSavingsSM
Savings through select providers

PacifiCare SignatureSavings

Application for Participation

PacifiCare
SignatureSavingsSM

Savings through select providers

INSTRUCTIONS FOR COMPLETING APPLICATION

- **Check all appropriate boxes and print all information clearly.** (Please retain the brochure information until you receive your ID card.)
- **Applicant:** Fill out section completely. ■ **Dependents:** All dependents you wish to be included should be listed in this section.
- **Payment Options:** Please check the box for your selected participation.
- **Method of Payment:** Please indicate your preferred method of payment: Credit Card, Checking Account Auto Pay or one-time Annual Check payment. Should you choose the Monthly Auto Pay option (by Credit Card or Checking Account), PacifiCare Dental and Vision Administrators will then automatically deduct the monthly payment from your checking account or charge the amount to your credit card. Or if you select the Annual Payment option, you may either pay by credit card or include a check made payable to PacifiCare Dental and Vision Administrators for the annual amount and one-time enrollment and processing fee of \$15.00. Sign in the box at the "X" on the bottom of this sheet. This form must be signed for your participation to begin.
- **Mail to: PACIFICARE SIGNATURESAVINGS, LC05-342, P.O. BOX 25187, SANTA ANA, CA 92799-5187**

APPLICANT (You)

Please complete all sections. This form cannot be processed if information is incomplete.

Last Name		First Name		MI
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number	Home Phone ()
Mailing Address		City	State	ZIP Work Phone ()

DEPENDENTS LIVING WITH YOU

Attach additional sheets if necessary.

1	Last Name	First Name	MI	Relationship
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number	
2	Last Name	First Name	MI	Relationship
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number	
3	Last Name	First Name	MI	Relationship
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number	

PAYMENT OPTIONS

For Monthly Auto Pay, the amount will be deducted from your credit card or checking account each month.

Please check one option: Individual (monthly auto pay) \$8.95* Family (monthly auto pay) \$10.95* **Please include a one-time enrollment and processing fee of \$15 per application.*
 Individual (annual) \$107.40* Family (annual) \$131.40*

Effective Date: First of current month First of next month _____ (month)

METHOD OF PAYMENT

Choose from Option A, B or C.

A. Bill my Credit Card (check one) Visa American Express MasterCard Discover

Name on Credit Card: _____

Account Number: _____ Expiration Date: _____

Billing Address (if different from mailing address): _____

B. Bill my Checking Account *(include voided check with the application)*

Bank/Institution Name: _____ Routing Number: _____

Name of Account Holder: _____ Account Number: _____

C. Check is enclosed for the Annual Rate (please make check payable to PacifiCare Dental and Vision Administrators)

AUTHORIZATION

I authorize PACIFICARE DENTAL AND VISION ADMINISTRATORS to bill my credit card or checking account for the program I have selected. This charge shall remain in force until I inform PACIFICARE DENTAL AND VISION ADMINISTRATORS, in writing, of its cancellation. I understand the terms and conditions of the program as described on the attached brochure.



X

Applicant Signature _____ Date _____

PacifiCare SignatureSavings is offered by PacifiCare Dental and Vision Administrators, a division of PacifiCare Health Plan Administrators, Inc. PacifiCare SignatureSavings is not an insurance or managed care dental or vision product. Participation is based on a 12-month period that begins on your first effective day of the program.

THIS PORTION FOR AGENT AND BROKER USE ONLY

Agent Name	Stratum Insurance Agency LLC	Agent Number	7786	Agent Phone	(949) 270-0609
Agent Address	PO Box 4557	City	Irvine	State	CA ZIP 92616
PacifiCare Representative Name		Producer ID#		Sales Office	PHS Code

PDV-105-74067
PDVEW1095-003

