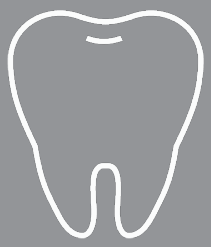


DENTAL, VISION, & HEARING

Flexible Choice Dental, Vision, & Hearing Application Booklet for Colorado

- **Application**
- **Electronic funds transfer agreement**
- **HIPAA notices**
- **Replacement notice**

Together, all the way.®

Cigna®

Insured by Loyal American Life Insurance Company

912132 07/21

APPLICATION for DENTAL, VISION, & HEARING INSURANCE

Insured by Loyal American Life Insurance Company®
PO Box 5725, Scranton, PA 18505 • 866-459-4272

Application is for: ☐ New business ☐ Reinstatement

Requested effective date *(MM/YYYY)* _____
(The effective date will be the 1st of the month selected. If left blank, we will assign the 1st day of the month following the date of the application.)

THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

A. Personal information

Primary Applicant **Name** *(First MI Last)*	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female
Resident address *(Street, City, State ZIP)*		**Phone** *(XXX-XXX-XXXX)*
Mailing address *(if different from resident address)*		**Social Security no.** *(XXX-XX-XXXX)*
Email address *(optional)*		

Spouse **Name** *(First MI Last)*	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female
Child 1 **Name** *(First MI Last)*	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female
Child 2 **Name** *(First MI Last)*	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female
Child 3 **Name** *(First MI Last)*	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female
Child 4 **Name** *(First MI Last)*	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female

B. Benefit plan selection

Coverage type: ☐ Primary Applicant ☐ Primary Applicant and Spouse ☐ One-Parent Family ☐ Family

Dental, Vision, & Hearing coverage

Policy year benefit maximum *(per insured person)*
☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $5,000

Policy year deductible *(per insured person)*
☐ $100 ☐ $50 ☐ $0 ☐ $100 Disappearing deductible

☐ Preventive services covered at 100%

Total premium $ _____

C. Choose your method of payment

Method *(select one of the following)*:

☐ Electronic funds transfer (bank draft) *(complete the Electronic Funds Transfer Authorization form)*

☐ Direct bill *(enclose check payable to* **Loyal American Life Insurance Company***; do not send cash)*

☐ List bill *(payroll deduction)*

Mode: ☐ Monthly *(bank draft or payroll deduction only)* ☐ Bi-weekly ☐ Semi-monthly
☐ Quarterly ☐ Semi-annually ☐ Annually

Group name _____ Group # _____ Is this a Section 125? ☐ Yes ☐ No

D. Prior or other coverage

		APPLICANT YES	APPLICANT NO	SPOUSE YES	SPOUSE NO
1.	Is the insurance applied for here intended to replace any existing or pending dental insurance?	☐	☐	☐	☐
2.	Is any Applicant eligible for Medicare?	☐	☐	☐	☐

If YES, please provide the following (and complete the Replacement Notice):

Applicant: Name of company _____ Policy no. _____

Spouse: Name of company _____ Policy no. _____

If you are replacing an existing dental plan, we will waive the waiting period applicable to dental benefits under this policy.

E. Important statements for Applicant to read

I hereby apply to Loyal American Life Insurance Company (hereinafter "Company" and "Loyal") for insurance coverage to be issued based upon the truth and completeness of the answers to the above questions and understand and agree that:

1. no agent has the authority to waive the answer to any question on the application;
2. no insurance will be effective until (a) this signed application has been accepted upon review of the answers I have provided and any medical information reviewed by Loyal, (b) the initial premium has been paid, and (c) a contract has been issued by the Company; and
3. I have received the Outline of Coverage for the policy applied for, the Replacement Notice form if applicable, and, if eligible for Medicare, the required *Guide to Health Insurance for People with Medicare*.

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.

The Primary Applicant must sign and date, acknowledging their understanding and agreement to the conditions listed herein. The above statements are true and complete. I understand and agree that for all Applicants these statements shall be the basis for determination of acceptance for coverage under my applicable Loyal policy. I acknowledge and agree that any material misrepresentation or material omission regarding any Applicant may render this contract null and void from its date of issue in accordance with applicable law. If coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. Loyal will return all paid premiums and fees less any claim payments.

As an alternative to court action, any matter in dispute between me and the Company may be subject to binding arbitration governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association. Any decision reached by arbitration shall be binding upon both myself and the Company and may be entered as a judgment in any court of proper jurisdiction. By signing this application, I acknowledge that I am giving up the right to a trial in court, both with and without a jury.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

Primary Applicant's signature	Today's date *(MM/DD/YYYY)*

F. Agent use only

I certify that I have provided the Primary Applicant with the following documents:

a. Application packet b. Outline of Coverage c. Other _____

I certify that I have interviewed the Primary Applicant, asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Primary Applicant. ☐ Check box if Agent family business

If you would like level commissions to be paid on this policy, check this box ☐; otherwise, heaped commissions will be paid. If you are a Licensed Only Agent (LOA), check with your management before requesting level commissions. Please refer to your commission schedule for heaped and level commission rates.

Printed name of licensed Agent	Signature of licensed Agent	Writing number	Percentage
Printed name of 2nd licensed Agent		Writing number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO BOX 5725 • SCRANTON, PA 18505-5725

Proposed Insured's Name		**Policy Number (if available)**
Financial Institution Name and Telephone Number		
Financial Institution Address		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date (1st - 28th)**

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

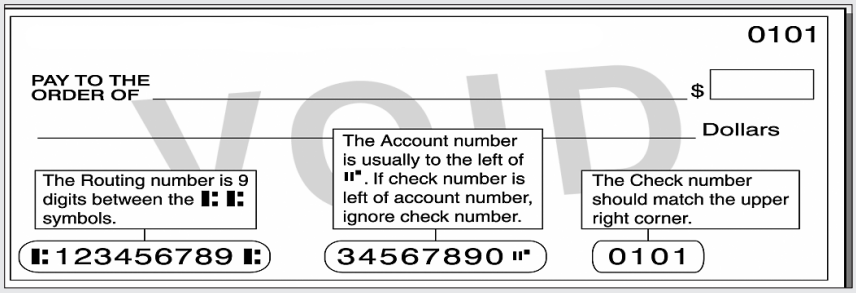
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.



APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Loyal American Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Loyal American Life Insurance Company mistakenly deposits funds into my account, I authorize Loyal American Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR LOYAL AMERICAN LIFE INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Loyal American Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Loyal American Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) **Payor's Address**

Print name of Depositor (as it appears on account) **Signature of Depositor** **Date**

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB Group, LLC, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB Group, LLC, information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB Group, LLC.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
7. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
8. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
9. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
10. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

_____
Applicant's Name

_____
Name of Applicant's Personal Representative, if applicable

_____
Applicant's Social Security Number

_____
Relationship of Personal Representative to the Applicant

_____
Signature of Applicant **Date**

_____
Signature of Personal Representative **Date**

_____
Signature of Company's Agent **Date**

A signed copy of this form will be provided with the policy if issued and any other time upon request.

AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES ("Authorization")

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

_____

_____ _____

Consumer's Name **Name of Consumer's Personal Representative, if applicable**

_____ _____

Signature of Consumer **Date** **Relationship of Personal Representative to the Consumer**

_____ _____

Signature of Company's Agent **Date** **Signature of Personal Representative** **Date**

A signed copy of this form will be provided to you.

Loyal American Life Insurance Company®
PO Box 5725, Scranton, PA 18505-5725
Toll Free: 866-459-4272

NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE

According to your application and the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Loyal American Life Insurance Company®. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision, you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER
I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other (please specify)

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

2. State law provides that your replacement policy or contract may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The issuer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Signature of Producer

_____
Name and Address of Issuer

_____ _____
Applicant's Signature Date