❑ New Application
❑ Reinstatement
❑ Benefit Change

ManhattanLife Insurance and Annuity Company

10777 Northwest Freeway, Houston, TX 77092

Dental Insurance Application

PROPOSED INSURED'S INFORMATION

Proposed Insured's Name (First, Middle, Last)		Date of Birth (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)			
Telephone Numbers (Home, Work, and Cell)		Email Address	
Social Security Number	Requested Effective Date	Mail Policy to: ❒ Agent ❒ Policyowner	

OWNER'S INFORMATION FOR "CHILD(REN) Only" Coverage

Name (First, Middle, Last)	Relationship to the Child(ren)
Address (Street, City, State, ZIP Code)	
Telephone Numbers (Home, Work, and Cell)	Email Address

OTHER PROPOSED INSURED(S)

Name (First, Middle, Last)	Relationship to Proposed Insured	Date of Birth (MM/DD/YYYY)	Gender (M/F)	Social Security No.

GENERAL QUESTIONS

1. Do you, or any proposed insured(s), have any similar insurance coverage, for which you are applying for, currently in force? ❑ Yes ❑ No If, "**Yes**," provide type of contract, policy number, and the name of company:

2. Is the policy being applied for intended to replace any other insurance? ❑ Yes ❑ No If, "**Yes**," provide type of contract, policy number, and the name of company:

COVERAGE APPLIED FOR

	Coverage:	Rider(s):	Premium:
DENTAL EXPENSE POLICY	❑ Individual ❑ Individual/Child ❑ Individual/Spouse ❑ Child(ren) Only ❑ Family Policy Year Deductible: ❑ $0 ❑$100 Policy Year Maximum: ❑ $1,000 ❑ $1,500 ❑ $3,000 ❑ $5,000	Hearing Expense ❑ Yes ❑ No Vision Expense ❑ Yes ❑ No Contact Lenses/Frames: ❑ $200	$ _____Base Policy $ _____Hearing Rider $ _____Vision Rider $ _____Total

EMAIL CONSENT AUTHORIZATION

❒ I give my written consent to allow ManhattanLife Insurance and Annuity Company (Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(es) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company in writing of such revocation.

❒ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below.)

Primary email address: _____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

Submit Completed Form to: New Business Department, 10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone Number: (800) 999-2971

INSURED'S AUTHORIZATION AND SIGNATURE

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete, and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by ManhattanLife Insurance and Annuity Company (Company), the full first premium has been paid, and the policy has been delivered to the applicant; and, (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

I, the undersigned applicant, certify that I have read, or had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I have received the Outline of Coverage for the policy (in states required by law).

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

CAUTION: If your answers on this application are incorrect and untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind the policy.

THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE ADMINISTRATIVE OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED.

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

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a 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.

Signed at _____ this _____ Day of _____ 20 _____

City, State

X _____ X _____

Signature of Primary Insured
(Parent if person to be insured is less than 15 years old)

Payor/Owner
(if other than Proposed Insured)

AGENT'S STATEMENT AND CERTIFICATION

All information recorded by me on this application is true and accurate to the best of my knowledge.

Agent No. | Soliciting Agent Signature | Date

Printed Agent Name | Agent Phone No. | Agent's License No.

PAYMENT OPTIONS AUTHORIZATION

❑ **Payroll Deduction (Listbill)**

Assigned list bill number, if known:_____

I hereby authorize my employer to deduct from my salary and pay to ManhattanLife Insurance and Annuity Company the premium.

❑ **Automatic Bank Draft (Electronic Funds Transfer)**

❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

Type of Account: ❑ Checking ❑ Savings

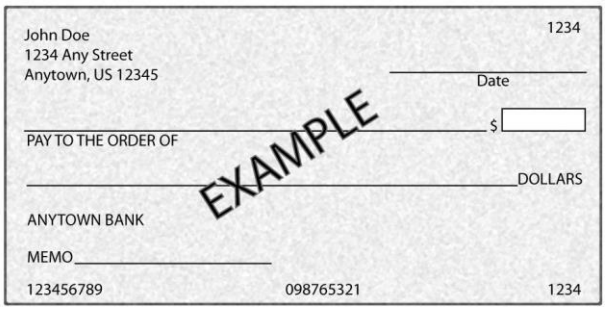
Desired withdrawal date (Between the 1st and the 28th)_____

Bank name:_____

City:_____State:_____

Routing number (9 Digits):_____

Account number:_____



↑ Routing Number ↑ Account Number

Authorization for Electronic Funds Transfer (EFT)

I (we) hereby authorize ManhattanLife Insurance and Annuity Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder's Signature_____ Date_____

❑ **Bill Me Directly** ❑ Quarterly ❑ Semi-Annually ❑ Annually

If your billing address is different than your home address, please enter it below:

Billing Address: _____

(Street) (City) (State) (Zip)

Name of person paying, if different: _____