## New Application

Reinstatement
Benefit Change

## ManhattanLife Insurance and Annuity Company

10777 Northwest Freeway, Houston, TX 77092

**Dental Insurance Application** 

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, Midel, Last)       Relationship to the Child(ren)         Address (Street, City, State, ZIP Code)       Telephone Numbers (Home, Work, and Cell)       Email Address         OTHER PROPOSED INSURED(S)       Relationship to       Date of Birth (MM/DD/YYYY)       Gender       Social Security No.         Name (First, Middle, Last)       Proposed Insured       MM/DD/YYYY)       Gender       Social Security No.         COVERAGE AVENUED(S)       Relationship to       Date of Birth (MM/DD/YYYY)       Gender       Social Security No.         I. 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:	<b>PROPOSED INS</b>	URED'S INFORMATION						
Social Security Number       Requested Effective Date       Mail Policy to: □ Agent □ Policyowner         OWNER'S INFORMATION FOR "CHILD[REN] Only" Coverage       Relationship to the Child(ren)         Address (Street, City, State, ZIP Code)       Telephone Numbers (Home, Work, and Cell)       Email Address         OTHER PROPOSIED INSURED(S)       Relationship to Proposed Insured       Date of Birth (MMDD/YYYY)       Gender       Social Security No.         CHER PROPOSIED INSURED(S)       Relationship to Proposed Insured       Date of Birth (MMDD/YYYY)       Gender       Social Security No.         CENERAL OUESTIONS       Individual (Social Security No. 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:	Proposed Insured's	Date of Birth	(MM/DD/YY)	YY) Gender (M/F)				
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Name (First, Middle, Last)       Relationship to the Child(ren)         Address (Street, City, State, ZIP Code)       Email Address         Telephone Numbers (Home, Work, and Cell)       Email Address         OTHER PROPOSED INSURED(S)       Relationship to Proposed Insured       Out of Birth       Gender       Social Security No.         Name (First, Middle, Last)       Proposed Insured       (MMDDP/YYY)       (MF)       Social Security No.         GENERAL QUESTIONS       Image of the stress of the	Social Security Nu	mber	Requested Effective Date		Mail Policy to:	Mail Policy to: C Agent C Policyowner		
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Telephone Numbers (Home, Work, and Cell)       Email Address         OTHER PROPOSED INSURED(S)       Relationship to       Date of Birth       Gender       Social Security No.         Name (First, Middle, Last)       Proposed Insured       (MMDD/YYYY)       Gender       Social Security No.         GENERAL QUESTIONS       Image: Comparison of the second of the s		•	, , ,		Relationship to th	e Child(ren)		
OTHER PROPOSED INSURED(s)       Relationship to Proposed insured       Date of Birth (MMIDD/YYYY)       Gender (MF)       Social Security No.         Proposed insured       MMIDD/YYYY)       Gender       Social Security No.         Proposed insured       (MMIDD/YYYY)       Gender       Social Security No.         Proposed insured       (MMIDD/YYYY)       Gender       Social Security No.         Gender       (MIDD/YYYY)       Gender       Gender         I Doyou, or any proposed insured(s), have any similar insurance coverage, for which you are applying for, currently in force?       Yes No       No         I. Doyou, or any proposed insured(s), have any similar insurance coverage, for which you are applying for, currently in force?       Yes No       No         I. Doyou, or any proposed insured(s)       Individual/Child       Medres/Si       Medres/Si	Address (Street, C	ity, State, ZIP Code)						
Name (First, Middle, Last)       Relationship to Proposed Insured       Date of Birth (MM/DD/YYYY)       Gender (MM/DD/YYYY)       Social Security No.         Image: Constraint of the second secon	Telephone Numbe	rs (Home, Work, and Cell)			Email Address			
Proposed Insured       (MM/DD/YYYY)       (M/F)         Image: Construct Construc	OTHER PROPOSI	ED INSURED(S)						
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:         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:         COVERACE APPLIED FOR         DENTAL         EXPENSE         PAGING         POLICY         Policy Year Deductible: □ \$0 □\$100         Policy Year Deductible: □ \$1,000         Policy Year Deductible: □ \$1,000         Policy Year Maximum: □ \$1,000         I give my written consent to allow ManhatanLife 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) hat 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) provide 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 addresss below.)         Primary email address:	Name (First, Middle	e, Last)					Social Security No.	
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name of company:         COVERAGE APPLIED FOR         DENTAL       Coverage:       Individual/Spouse       Individual/Child       Hearing Expense       Yes       No         DENTAL       Coverage:       Individual/Spouse       Child(ren) Only       Family       Base Policy       #earing Rider         POLICY       Policy Year Deductible:       \$0 \$\$100       S100       \$\$1,500       \$\$200       #earing Rider         \$				]Ves □No If	" <b>Ves</b> " provide type	a of contract	policy number, and the	
DENTAL       Coverage:       Individual/Child       Individual/Spouse       Child(ren) Only         EXPENSE       Policy       Family       Coverage:       S       Base Policy         POLICY       Family       Policy Year Deductible:       \$0 \$100       Signon \$1,500       \$1,500         Policy Year Maximum:       \$1,000 \$1,500       \$1,500       \$200       \$								
DENTAL       Coverage:       Individual/Child       Individual/Spouse       Child(ren) Only         EXPENSE       Policy       Family       Coverage:       S       Base Policy         POLICY       Family       Policy Year Deductible:       \$0 \$100       Signon \$1,500       \$1,500         Policy Year Maximum:       \$1,000 \$1,500       \$1,500       \$200       \$	<b>COVERAGE</b> A	PPLIED FOR						
<ul> <li>\$</li></ul>	Coverage:         Individual         Individual/Spouse         Individual/Spouse         Child(ren)         Family         POLICY		Hearing Expense □ Yes □ No Vision Expense □ Yes □ No Contact Lenses/Frames:		\$ \$	S Base Policy     S Hearing Rider     S Vision Rider		
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the event that the address should change.	<ul> <li>I give my saddress(es further agree below. I acled be</li></ul>	written consent to allow Ma ) listed below. I confirm that be to indemnify and hold har knowledge that, should I des give consent to the Compan- nail address: email address: cant electing to allow for no insurer rightfully considers notice of cancellation. Ther	at I have authorization to pro- mless the Company for any sire to revoke this written authorization to communicate with me b 	ovide consent for action or loss aris norization, I will in y email. (Do not p be sent to the el y the applicant that	email to the email ing from any incorre form the Company provide email addre ectronic mail addre at all notices may b	address(es) ect or false en in writing of su sses below.) ess provided b e sent electroi	that I provide below and nail address(es) provided uch revocation.	

ManhattanLife. Standing By You. Since 1850.

## 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).

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, Sta	te		
X	Х		
Signature of Prima (Parent if person to be insured in	less than 15 years old)	Payor/Owner (if other than Proposed Insured)	
AGENT'S STATEMENT AND CERTI	FICATION		
All information recorded by me on this app	lication is true and accurate to the best	of my knowledge.	
Agent No.	Soliciting Agent Sig	nature	Date
Printed Agent Name	Agent Phone	e No.	Agent's License No.

## PAYMENT OPTIONS AUTHORIZATION

Payroll Deduction (Listbill)		
Assigned list bill number, if known:	John Doe	1234
I hereby authorize my employer to deduct from my salary and pay to	1234 Any Street	
ManhattanLife Insurance and Annuity Company the premium.	Anytown, US 12345	Date
Automatic Bank Draft (Electronic Funds Transfer)	PAY TO THE ORDER OF	<u>، المعالم الم</u>
🗅 Monthly 🗖 Quarterly 🖵 Semi-Annually 🗖 Annually	JAN.	DOLLARS
Type of Account: 🛛 Checking 🗳 Savings	EN	
	ANYTOWN BANK	
Desired withdrawal date (Between the 1st and the 28th)	MEMO	
\ \	123456789 098765321	1234
Bank name:		
City: State:		
Routing number (9 Digits):	Routing Number Account Num	ber
Account number:		
I (we) hereby authorize ManhattanLife Insurance and Annuity Company, he and depository, hereinafter called DEPOSITORY, to debit the same to such COMPANY and DEPOSITORY have received written notification from me ( to afford COMPANY and DEPOSITORY a reasonable opportunity to act on	n account. This authority is to remain in full fo or either of us) of its termination in such time	prce and effect until
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:	r.	
	ity) (State)	(Zip)
Name of person paying, if different:		Λ Γ <i>Ι</i>