❑ New Application
❑ Reinstatement
❑ Policy Change

ManhattanLife Insurance and Annuity Company

10777 Northwest Freeway, Houston, TX 77092

Dental, Vision, and Hearing Insurance Application

WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICANT INFORMATION

Name (Last, First, Middle Initial)	Date of Birth	Gender (M/F)

Address (Street, City, State, ZIP Code)	

Telephone Numbers (Home, Work, and Cell)	Email Address

Social Security Number	Requested Effective Date (optional):	Mail Policy To: ❒ Insured ❒ Agent

DEPENDENT(S) INFORMATION

Name (Print Full Name)	Social Security Number	Gender (M/F)	Date of Birth

GENERAL QUESTIONS

1. (a) Do you, or any proposed insured persons, have any dental, vision, or hearing insurance currently in force?	❑ Yes ❑ No
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company ? . . . . . If "Yes," provide type of contract or policy number, and name of company: _____	❑ Yes ❑ No
(c) If replacement is involved, have you received a replacement form (in states required by law)?	❑ Yes ❑ No

COVERAGE APPLIED FOR

Dental, Vision, and Hearing	❑ Applicant Only ❑ Family (Family Coverage is up to 5 persons) Policy Year Maximum: ❑ $1,000 ❑ $1,500 ❑ $3,000 ❑ $5,000 Premiums: _____

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 notices, other than change in premium rate, 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.

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.

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.

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO MANHATTANLIFE INSURANCE AND ANNUITY COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

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.

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)

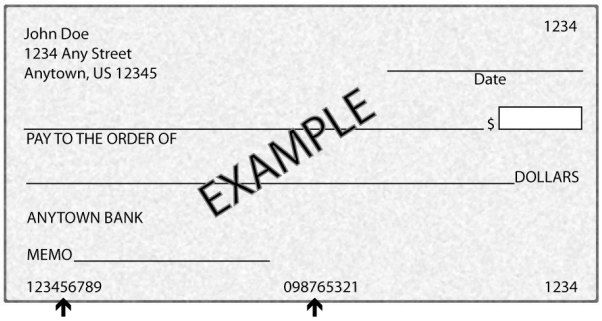
PAYMENT OPTIONS AUTHORIZATION

❑ Monthly Payroll Deduction (Listbill)

Assigned list bill number, if known:_____
I hereby authorize _____(Name of Employer)
to deduct from my salary and pay to ManhattanLife Assurance Company of America
beginning with the month of _____, 20_____ ,
a deduction of $_____ each month.
Signature of Employee_____ Date_____

❑ Monthly Automatic Bank Draft (Electronic Funds Transfer)

Desired withdrawal date (Between the 1st and the 28th)_____
Bank name:_____
City:_____ State:_____
❑ Checking ❑ Savings
If checking account, 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 (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.

_____ _____
Bank Accountholder's Signature Exactly as it appears on Bank Records Date

❑ Bill Me Directly: ❑ Quarterly ❑ Semi-Annual ❑ Annual 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: _____