□ New Application□ Reinstatement ■ Benefit Change

ManhattanLife Insurance and Annuity Company

10777 Northwest Freeway, Houston, TX 77092

Dental Insurance Application

PROPOSED INSU	JRED'S INFORMATION	l				
Proposed Insured's	Name (First, Middle, Last)			Date of Birtl	h (MM/DD/YYYY) Gender (M/F)
Address (Street, Cit	y, State, ZIP Code)					•
Telephone Numbers	s (Home, Work, and Cell)			Email Address		
Social Security Num	ber	Requested Effective Date		Mail Policy to:	J Agent ☐ Po	olicyowner
OWNER'S INFORM	IATION FOR "CHILD(REN	l) Only" Coverage				
Name (First, Middle	, Last)	-		Relationship to the	ne Child(ren)	
Address (Street, Cit	y, State, ZIP Code)			1		
Telephone Numbers	s (Home, Work, and Cell)			Email Address		
OTHER PROPOSE	D INSURED(S)					
Name (First, Middle	, Last)	Relationship Proposed Ins		Date of Birth M/DD/YYYY)	Gender (M/F)	Social Security No.
GENERAL QUES						
1	, , ,	ny similar insurance coverage,	for which you are	applying for, curre	ently in force?	Yes □ No It, " Yes ,"
	ract, policy number, and the	· •	7 V [7] N - £ "	V "id- t	fttt	
name of company		place any other insurance?	res uno it,	res, provide type	e of contract, poi	icy number, and the
COVERAGE A	PPLIED FOR					
	Coverage:		Rider(s):		Premium:	
		Individual/Child		se 🗆 Yes 🗆 No	\$	Base Policy
DENTAL	☐ Individual/Spouse☐☐ Family☐		Vision Expense □ Yes □ No Contact Lenses/Frames:			Hearing Rider
EXPENSE	Policy Year Deductible:	□ \$0 □\$100	□ \$200	3C3/1 Tames.	\$	Vision Rider
POLICY	Policy Year Maximum:	□ \$1,000 □ \$1,500	_ +=+		œ.	Total
	\$3,000 \$5,000				\$	1 Otal
EMAIL CONS						
	ENT AUTHORIZATION written consent to allow I	ManhattanLife Insurance and	Annuity Compar	ny (Company) to	communicate v	with me by email to the
		at I have authorization to provi				
		s the Company for any action				
		revoke this written authorizati any to communicate with me b				ocation.
		any to communicate with the b			esses below.)	
Secondary	email address:					
Signature:		Date:				
		otices and communications to				
		is election to be consent by th ore, the applicant should be d				
	dress should change.	ore, the applicant should be u	gent in upuating			

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 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.

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 quilty of a crime and may be subject to fines and confinement in prison.

this

Day of

City, S	State		
X		X	
Signature of Pri (Parent if person to be insure		Payor/Owner (if other than Proposed Insured)	
AGENT'S STATEMENT AND CER	TIFICATION		
All information recorded by me on this a	pplication is true and accurate to the	best of my knowledge.	
Agent No.	Soliciting Ag	Soliciting Agent Signature	
Printed Agent Name	Agen	t Phone No.	Agent's License No.

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Signed at

□ 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)	John Doe 1234 Any Street Anytown, US 12345 PAY TO THE ORDER OF ANYTOWN BANK MEMO	EXAMPLE	Date
Bank name:	123456789	098765321	1234
City: State:	^	A	
Pouting number (0 Digite):	Routing Number	Account Number	
Routing number (9 Digits):	Routing Number	Account Number	
Routing number (9 Digits):	onic Funds Transfer (EF /, hereinafter called COMPAN such account. This authority is ne (or either of us) of its termi	r) Y, to initiate debit entries to remain in full force a	and effect until
Routing number (9 Digits): Account number: Authorization for Electr I (we) hereby authorize ManhattanLife Insurance and Annuity Company and depository, hereinafter called DEPOSITORY, to debit the same to some COMPANY and DEPOSITORY have received written notification from received written notif	onic Funds Transfer (EF /, hereinafter called COMPAN such account. This authority is me (or either of us) of its termi et on it.	r) Y, to initiate debit entries to remain in full force a	and effect until
Routing number (9 Digits): Account number: Authorization for Electron I (we) hereby authorize ManhattanLife Insurance and Annuity Company and depository, hereinafter called DEPOSITORY, to debit the same to a COMPANY and DEPOSITORY have received written notification from recommendation to afford COMPANY and DEPOSITORY a reasonable opportunity to account to the same to a second to the same to the same to a second to the same to the same to a second to the same to the sa	onic Funds Transfer (EF	r) Y, to initiate debit entries to remain in full force a	and effect until