

- 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: <input type="checkbox"/> Agent <input type="checkbox"/> 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

DENTAL EXPENSE POLICY	Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Individual/Child <input type="checkbox"/> Individual/Spouse <input type="checkbox"/> Child(ren) Only <input type="checkbox"/> Family Policy Year Deductible: <input type="checkbox"/> \$0 <input type="checkbox"/> \$100 Policy Year Maximum: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	Rider(s): Hearing Expense <input type="checkbox"/> Yes <input type="checkbox"/> No Vision Expense <input type="checkbox"/> Yes <input type="checkbox"/> No Contact Lenses/Frames: <input type="checkbox"/> \$200	Premium: \$ _____ 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.



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

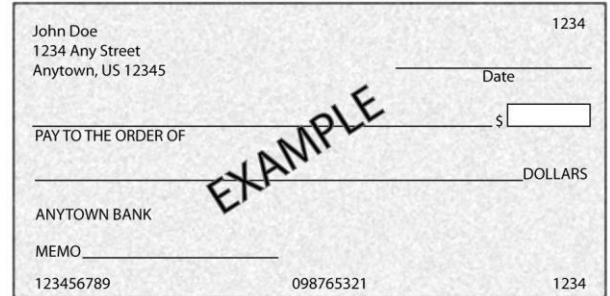
Desired withdrawal date (Between the 1st and the 28th) _____

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: _____