

- New Application
- Reinstatement
- Policy Change

ManhattanLife Assurance Company of America

10777 Northwest Freeway, Houston, TX 77092
Dental, Vision, and Hearing Insurance Application

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.

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: <input type="checkbox"/> Insured <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) If replacement is involved, have you received a replacement form (in states required by law)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

COVERAGE APPLIED FOR	
Dental, Vision, and Hearing	<input type="checkbox"/> Applicant Only <input type="checkbox"/> Family (Family Coverage is up to 5 persons) Policy Year Maximum: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 Premiums: _____

EMAIL CONSENT AUTHORIZATION
<input type="checkbox"/> I give my written consent to allow ManhattanLife Assurance Company of America (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 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 at their Administrative Office of such revocation. <input type="checkbox"/> 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: _____
<p>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.</p>

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. _____



