■ 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.

Name (Last, First, Middle Initial) Address (Street, City, State, ZIP Code) Felephone Numbers (Home, Work, and Cell) Social Security Number Requested Effective Date (optional): DEPENDENT(S) INFORMATION Name (Print Full Name) Social Security Num	g insurance currently in force?	Gender (M/F) Date of Birth □ Yes □ No	
Felephone Numbers (Home, Work, and Cell) Social Security Number Requested Effective Date (optional): DEPENDENT(S) INFORMATION	Mail Policy To: Insured Agent Therefore Gender (M/F) g insurance currently in force?		
Social Security Number Requested Effective Date (optional): DEPENDENT(S) INFORMATION	Mail Policy To: Insured Agent Therefore Gender (M/F) g insurance currently in force?		
DEPENDENT(S) INFORMATION	g insurance currently in force?		
	g insurance currently in force?		
	g insurance currently in force?		
Name (Filit Full Name)	g insurance currently in force?		
		Yes No	
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	
		☐ Yes ☐ No	
		□ Yes □ No	
GENERAL QUESTIONS		☐ Yes ☐ No	
. (a) Do you, or any proposed insured persons, have any dental, vision, or hearing			
(b) Is the insurance applied for intended to replace any existing insurance with the	his or any other company?	· · · □ Yes □ No	
If "Yes," provide type of contract or policy number, and name of company: _			
(c) If replacement is involved, have you received a replacement form (in states r	required by law)?	□ Yes □ No	
(,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,,			
COVERAGE APPLIED FOR			
☐ Applicant Only ☐ Family (Family Covera	age is up to 5 persons)		
Dental, Vision, and Hearing Policy Year Maximum: \$1,000 \$1,500	y Year Maximum: ☐ \$1,000 ☐ \$1,500 ☐ \$2,000 ☐ \$2,500 ☐ \$3,000 Premium		
7 oney 1 out Maximum. 2 \$1,000 2 \$1,000	2 \$2,000		
EMAIL CONSENT AUTHORIZATION			
☐ I give my written consent to allow ManhattanLife Assurance Company of A	America (Company) to communicate with me by	email to the address(es	
listed below. I confirm that I have authorization to provide consent for ema	ail to the email address(es) that I provide below	and further agree to hol	
harmless the Company for any action or loss arising from any incorrect desire to revoke this written authorization, I will inform the Company in wri			
☐ I decline to give consent to the Company to communicate with me by ema			
Primary email address:			
Secondary email address:			
Signature: Date:			
Note: The applicant electing to allow for notices and communications to be so			
aware that the insurer rightfully considers this election to be consent by the apprenewal and notice of cancellation. Therefore, the applicant should be diligent in			
that the address should change.	rapading in olociono man address provided t	to the medici in the ever	
AGENT'S STATEMENT AND CERTIFICATION			
All information recorded by me on this application is true and accurate to the best	st of my knowledge.		
Agent No. Soliciting A	Agent Signature	Date	
Drinted Agent Name	Agent's License No		
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 Assurance Company of America (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 ASSURANCE COMPANY OF AMERICA. 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

Signed at		this	Day of	20
	City, State			
X		Χ		
	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:	John Doe 1234 Any Street Anytown, US 12345 PAY TO THE ORDER OF	AMPLE	1234 Date
☐ Monthly Automatic Bank Draft (Electronic Funds Transfer)	(3)	T r.	DOLLARS
Desired withdrawal date (Between the 1st and the 28th)	ANYTOWN BANK MEMO		
Bank name: State:	123456789	098765321	1234
If checking account, routing number (9 Digits): Round Account number:	uting Number A	ccount Number	
AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT): I (we) hereby author to initiate debit entries to the account and depository, hereinafter called Depository, to company in full force and effect until Company and Depository have received written notificand in such manner as to afford company and depository a reasonable opportunity to a Bank Accountholder's Signature Exactly as it appears on Bank Records	lebit the same to such a ication from me (or eithe	ccount. This authority	is to
Bank Accountificities Signature Exactly as it appears on Bank Records	Date		
☐ Bill Me Directly: ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ If your billing address:	s is different than your h	ome address, please e	enter it below:
(Street) (City)	(S	State) (Zip)
Name of person paying, if different:			_