# Dental, Vision and Hearing Insurance

## A plan with choices for you and your family

This is a Limited Benefit Insurance Policy for Dental, Vision and Hearing Expenses
Underwritten by ManhattanLife Insurance Company of America and Manhattan Life Insurance Company.

DVH17-BR 0118

Not available in all states.

## The Importance of Dental • Vision • Hearing

- Quality of Life
- Unforeseen situations that are painful, inconvenient and expensive
- Basic Medicare does not cover dental, vision or hearing expenses.

## Products Highlights

- Choose your dentist - *No Networks*
- Family Rates (includes a maximum of 3 children)
- Individual 18 - 85
- $1,000 - $1,500 policy year benefit option available
- Guaranteed Issue
- Guaranteed renewable for life.*

** Subject to our right to change premiums.*

**Protect Your Smile . . . and Smile Brighter!**

**Protect Your Sight . . . and See Clearer!**

**Protect Your Hearing . . . and Hear Better!**

## Plan Benefits [1]

| | |
|---|---|
| **Eligibility** | Anyone age 18 - 85 |
| **Policy Year Maximum Benefit** | **$1,000 or $1,500** (choose one) |
| **Policy Year Deductible** | $100 per person |

### Dental Coverage

| | |
|---|---|
| **Preventive Services**<br>Semi-Annual exams, cleaning and x-rays. | **Year 1 - 60%**<br>**Year 2 - 70%**<br>**Year 3 and thereafter - 80%*** |
| **Waiting Period** | **None** |

**In OH, year 2 and thereafter is 70%*

| | |
|---|---|
| **Basic Services**<br>Including x-ray (other than "full mouth"), fillings and extractions | **Year 1 - 60%**<br>**Year 2 - 70%**<br>**Year 3 and thereafter - 80%*** |
| **Waiting Period** | **None** |

**In OH, year 2 and thereafter is 70%*

| | |
|---|---|
| **Major Services**<br>Including bridges, crowns, full dentures or partials, full mouth extractions, and root canals | **Year 1 - 0%**<br>**Year 2 - 70%**<br>**Year 3 and thereafter - 80%*** |
| **Waiting Period** | **12 months** |

**In OH, year 2 and thereafter is 70%*

### Vision Coverage

| | |
|---|---|
| Basic eye exam, eye refraction, including the cost of eye glasses or contact lenses | **Year 1 - 60%**<br>**Year 2 - 70%**<br>**Year 3 and thereafter - 80%*** |
| **Waiting Period** | **6 months**<br>on eyeglasses and contact lenses |

**In OH, year 2 and thereafter is 70%*

### Hearing Coverage

| | |
|---|---|
| Exam, hearing aid and necessary repairs or supplies | **Year 1 - 60%**<br>**Year 2 - 70%**<br>**Year 3 and thereafter - 80%** |
| **Waiting Period** | **12 months**<br>new hearing aids and existing hearing aid repairs |

**In OH, year 2 and thereafter is 70%*

[1] Refer to your policy for a complete description of limitations and exclusions.

## $1,000 Policy Year Maximum

**INDIVIDUAL MONTHLY PREMIUM**

| Age | Premium |
|---|---|
| 18 - 39 | $27.50 |
| 40 - 54 | $29.75 |
| 55 - 64 | $31.92 |
| 65 - 74 | $34.17 |
| 75 - 85 | $39.25 |

**FAMILY MONTHLY PREMIUM[2]**

| Age | Premium |
|---|---|
| 18 - 39 | $88.00 |
| 40 - 54 | $92.42 |
| 55 - 64 | $96.83 |
| 65 - 74 | $101.25 |
| 75 - 85 | $116.42 |

## $1,500 Policy Year Maximum

**INDIVIDUAL MONTHLY PREMIUM**

| Age | Premium |
|---|---|
| 18 - 39 | $36.33 |
| 40 - 54 | $38.50 |
| 55 - 64 | $41.83 |
| 65 - 74 | $45.17 |
| 75 - 85 | $51.92 |

**FAMILY MONTHLY PREMIUM[2]**

| Age | Premium |
|---|---|
| 18 - 39 | $116.17 |
| 40 - 54 | $120.58 |
| 55 - 64 | $127.17 |
| 65 - 74 | $133.75 |
| 75 - 85 | $153.83 |

Premiums are subject to change. Premium rates based on $1,000 or $1,500 Policy Year Maximum. Use the age of the oldest applicant. Benefit exclusions and limitations apply.

*[2] Family rates include up to three children. Additional children are charged the age 3 - 17 rate per person.*

| $1,000 Policy Year Maximum | |
|---|---|
| **Age** | **Premium** |
| 3 - 17 | $20.67 |
| **$1,500 Policy Year Maximum** | |
| 3 - 17 | $27.25 |

## THIRTY*-DAY RIGHT TO RETURN

Please read Your policy. If you are not satisfied for any reason, return the policy to the Company's Administrative Office or to Your Company sales Agent within 30 days after You receive it. As soon as You deliver or mail the policy to Us, it is treated as if it was never issued. We will return your premium paid, less any claims paid.

**In AZ, ID, IL, LA, MD, MO, OH, OK and PA the right to return is 10 days.*

## PRE-EXISTING CONDITIONS

The Policy and any attached Rider(s) do not cover Pre-Existing Conditions whether disclosed in the application or not, for the first 12 months beginning on the date that person becomes an Insured on the Policy. In MD, the Policy and any attached Rider(s), if any, do not cover Pre-Existing Conditions for the first 12 months beginning on the date that person becomes an insured on this Policy.

By Pre-Existing Conditions, We mean those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-months (In ID, OH and WY, 6 months) period immediately preceding the Policy Effective Date. In MD, with respect to Pre-Existing Conditions disclosed in the application, this Pre-Existing Condition Limitation will not include a condition revealed on the application for coverage, unless the condition was excluded by a signed waiver rider attached to the policy. In PA, medical advice or treatment was received or recommended by a Physician within the 12-month period preceding the Policy Effective Date.

Except in ID, conditions specifically named or described as excluded in any part of the Policy are never covered.

## EXCLUSIONS AND LIMITATIONS

We will NOT pay benefits for the following items and/or services during the first six (6) months following the Policy Effective Date: 1. Eyeglasses or contact lenses.

We will NOT pay benefits for the following items and/or services during the first Policy Year: 1. endodontics (including root canals), periodontal surgery, bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions, fluoride treatments, or outpatient dental surgery; or, 2. except in MT, hearing aids, including repairs. In MD, fluoride treatments does not apply.

We will NOT pay benefits for: 1. except in MI, any loss resulting from war, declared or undeclared (in OK, while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntary or as required by an employer); 2. except in IL, MI, any intentionally self-inflicted Injury; 3. except in MD, any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation. In ID, any loss to which a contributing cause was your participation in a felony, riot or insurrection; 4. any services that are not recommended by a Physician. In MI, any loss to which a contributing cause was the Insured's commission of or attempt to commit a felony or to which a contributing cause was the Insured being engaged in an illegal occupation or other willful criminal activity; 5. except in MD, any Experimental or Investigational procedure or treatment; 6. orthodontic treatment or dental implants; 7. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state; 8. expenses incurred for surgical procedures performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts) other than Medically Necessary outpatient dental surgery following the first policy year. (In MD, surgery must be prescribed by a physician. In MD, MT, TX, UT and WY, the reference to Medically Necessary does not apply); 9. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; 10. impacted wisdom teeth; 11. occlusal guards; 12. prescription drugs; 13. treatment or diagnosis received while outside the territorial limits of the United States; 14. services for which you are not liable or for which no charge normally is made in the absence of insurance (in MD, other than the benefits provided by Medicaid); and, 15. loss that occurs while this policy is not in force. (in MD, subject to the Extension of Benefits Provision).

In MD only, prohibited health care practitioner referrals.

In MT only, any Pre-Existing conditions as defined in the policy.

**TERMINATION -** All coverage under the Policy and any attached Rider(s) shall terminate when the Policy ceases to be in force. The Policy will end[1] on the earlier of: a. when You fail to pay Premiums within Your Grace Period; or, b. except in IL, when You die; or, c. the Policy Anniversary Date You no longer meet the Renewal Condition as defined on the cover of the Policy. In IL, the date We receive a request in writing to terminate this Policy or on a later date that is requested by You for termination; or, d. the date You notify Us in writing to end the Policy.

In IL only, the date We receive a request in writing to terminate this Policy or on a later date that is requested by You for termination ; the date all Policies the same as this one are non-renewed or terminated in the state in which this Policy was issued or the state in which You presently reside. We will give You 90 days advance notice, as required by state law, of the termination of Your coverage; the date You move to a state where We do not provide insurance under a Policy with the same Policy design as this Policy, We reserve the right to terminate this coverage; or, the Insured performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

Coverage for an Insured Dependent will end on the date such Insured ceases to be an Eligible Dependent Child or Eligible Spouse[2], as defined in the Policy. In UT, coverage for an Eligible Dependent Child shall continue in force through the last day of the month in which said Dependent Child ceases to be an Eligible Dependent Child, if premium has been paid for their birth month.

When such Insured's insurance ends, We will: a. consider any claim that began before the insurance ended; and, b. allow a conversion policy for an Eligible Dependent Child or Eligible Spouse[2], as set forth in the Conversion Privilege.

*[1] In IL, at 12:01 a.m. local time at Your state of residence.*
*[2] In DC and IL, Civil Union Partner; in CA and OR, Spouse or Domestic Partner; in MD, Eligible Covered Dependent, or Eligible Spouse/Domestic Partner; in NJ, Eligible Spouse, Eligible Domestic Partner, or Eligible Civil Union Partner.*

**This brochure is designed to give a brief description of the policies and optional benefits and does not constitute a contract. The exact terms, limitations, definitions, conditions and qualifications of a specific procedure or service will be found in the policy delivered to you. The terms of the policy govern.**

Policy Form Numbers: C-DVH16, C-DVH16-ID, C-DVH16-LA, C-DVH16-OK, C-DVH16-TX, M-DVH16 (including state variations)

Underwritten by:
ManhattanLife Insurance Company of America
Manhattan Life Insurance Company
10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone: 800-669-9030

❑ 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 and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime.**

## 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) | SSN/ITIN | 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)<br>Policy Year Maximum: ❑ $1,000 ❑ $1,500 Premiums: ______________ |

## EMAIL CONSENT AUTHORIZATION

❒ 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 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.

## 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. 43J22110000 | Soliciting Agent Signature | Date

Printed Agent Name Ann Gridley | Agent Phone No. 541-957-5000 | Agent's License No. 6232325

## 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 COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Signed at ____________________ this ______ Day of __________ 20 ______

City, State

X ______________________________
Signature of Primary Insured
(Parent if person to be insured is less than 15 years old)

X ______________________________
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________________

John Doe
1234 Any Street
Anytown, US 12345
1234
Date
PAY TO THE ORDER OF $
DOLLARS
EXAMPLE
ANYTOWN BANK
MEMO
123456789 098765321 1234

Routing Number Account Number

❑ **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:_________________________________________

**AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT)**: I (we) hereby authorize ManhattanLife Assurance Company of America(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: _________________________________