



DENTAL, VISION, & HEARING

Flexible Choice Dental, Vision, & Hearing Application Booklet for Florida

- › Application
- › Electronic funds transfer agreement
- › HIPAA notices
- › Replacement notice

Together, all the way.®



Insured by Loyal American Life Insurance Company

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APPLICATION for DENTAL, VISION, & HEARING INSURANCE

Insured by Loyal American Life Insurance Company®

PO Box 5725, Scranton, PA 18505 • 866-459-4272



Application is for: New business Reinstatement

Requested effective date (MM/YYYY) _____

(The effective date will be the 1st of the month selected. If left blank, we will assign the 1st day of the month following the date of the application.)

A. Personal information

PRIMARY APPLICANT

Name (First MI Last)

Date of birth (MM/DD/YYYY)

Gender

Male Female

Resident address (Street, City, State ZIP)

Phone (XXX-XXX-XXXX)

Mailing address (if different from resident address)

Social Security no. (XXX-XX-XXXX)

Email address (optional)

SPOUSE

Name (First MI Last)

Date of birth (MM/DD/YYYY)

Gender

Male Female

CHILD 1

Name (First MI Last)

Date of birth (MM/DD/YYYY)

Gender

Male Female

CHILD 2

Name (First MI Last)

Date of birth (MM/DD/YYYY)

Gender

Male Female

CHILD 3

Name (First MI Last)

Date of birth (MM/DD/YYYY)

Gender

Male Female

CHILD 4

Name (First MI Last)

Date of birth (MM/DD/YYYY)

Gender

Male Female

B. Benefit plan selection

Coverage type: PRIMARY APPLICANT PRIMARY APPLICANT AND SPOUSE ONE-PARENT FAMILY FAMILY

Dental, Vision, & Hearing coverage

Policy year benefit maximum (per insured person)

\$1,000 \$1,500 \$2,000 \$2,500 \$3,000 \$3,500 \$4,000 \$5,000

Policy year deductible (per insured person)

\$100 \$50 \$0 \$100 Disappearing deductible

Preventive services covered at 100%

Total premium \$ _____

C. Choose your method of payment

Method (select one of the following):

- Electronic funds transfer (bank draft) (complete the Electronic Funds Transfer Authorization form)
 Direct bill (enclose check payable to **Loyal American Life Insurance Company**; do not send cash)
 List bill (payroll deduction)

Mode: Monthly (bank draft or payroll deduction only) Bi-weekly Semi-monthly
 Quarterly Semi-annually Annually

D. Prior or other coverage

- | | | |
|--|---|---|
| | APPLICANT | SPOUSE |
| | YES NO | YES NO |
| 1. Is the insurance applied for here intended to replace any existing or pending dental insurance? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
- If YES, please provide the following (and complete the Replacement Notice):
 APPLICANT: Name of company _____ Policy no. _____
 SPOUSE: Name of company _____ Policy no. _____
 If you are replacing an existing dental plan, we will waive the waiting period applicable to dental benefits under this policy.
- | | | |
|--|---|---|
| 2. Is any Applicant eligible for Medicare? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
|--|---|---|

E. Important statements for Applicant to read

I hereby apply to Loyal American Life Insurance Company (hereinafter "Company" and "Loyal") for insurance coverage to be issued based upon the truth and completeness of the answers to the above questions and understand and agree that:

1. no agent has the authority to waive the answer to any question on the application;
2. no insurance will be effective until (a) this signed application has been accepted upon review of the answers I have provided, (b) the initial premium has been paid, and (c) a contract has been issued by the Company; and
3. I have received the Outline of Coverage for the policy applied for, the Replacement Notice form if applicable, and, if eligible for Medicare, the required *Guide to Health Insurance for People with Medicare*.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

The Primary Applicant must sign and date, acknowledging their understanding and agreement to the conditions listed herein. The above statements are true and complete. I understand and agree that for all Applicants these statements shall be the basis for determination of acceptance for coverage under my applicable Loyal policy. I acknowledge and agree that any material misrepresentation or material omission regarding any Applicant may render this contract null and void from its date of issue in accordance with applicable law. All statements in the application are representations and not warranties. If coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. Loyal will return all paid premiums and fees less any claim payments.

As an alternative to court action, any matter in dispute between me and the Company may be subject to voluntary arbitration subject to and administered in accordance with the Uniform Arbitration Act. Any decision reached by arbitration shall be binding upon both myself and the Company and may be entered as a judgment in any court of proper jurisdiction.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

Primary Applicant's signature	Today's date (MM/DD/YYYY)
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PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO BOX 5725 • SCRANTON, PA 18505-5725

Proposed Insured's Name		Policy Number (if available)
Financial Institution Name and Telephone Number		
Financial Institution Address		
9-digit Routing Number	Account Number	Requested Withdrawal Date (1st - 28th)

Withdraw Payment: Monthly Quarterly Semi-annually Annually

Type of Account: Personal Checking Account Personal Savings Account Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

- | | |
|--|---|
| <input type="checkbox"/> New authorization | <input type="checkbox"/> Change in checking/savings account |
| <input type="checkbox"/> Change in financial institution | <input type="checkbox"/> Change in existing coverage |

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.

0101

PAY TO THE ORDER OF _____ \$ _____

Dollars

The Routing number is 9 digits between the ■■■ symbols.
■ 123456789 ■

The Account number is usually to the left of "■". If check number is left of account number, ignore check number.
34567890 ■

The Check number should match the upper right corner.
0101

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS:

As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Loyal American Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Loyal American Life Insurance Company mistakenly deposits funds into my account, I authorize Loyal American Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR LOYAL AMERICAN LIFE INSURANCE COMPANY:

It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Loyal American Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Loyal American Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured)	Payor's Address
Print name of Depositor (as it appears on account)	Signature of Depositor
	Date

**AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S
PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES
("Authorization")**

1. I hereby authorize the use and disclosure of my protected personally identifiable health information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

Consumer's Name	Name of Consumer's Personal Representative, if applicable
Signature of Consumer	Relationship of Personal Representative to the Consumer
Signature of Company's Agent	Signature of Personal Representative
Date	Date

A signed copy of this form will be provided to you.

**NOTICE TO APPLICANT REGARDING
REPLACEMENT OF DENTAL INSURANCE**

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing dental insurance and replace it with a policy to be issued by Loyal American Life Insurance Company®. For your information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all questions on the application concerning your medical/health history are truthfully and completely answered. Failure to include all material medical information on any application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed, it should be carefully reviewed before being signed to be certain that all information has been properly recorded.
4. New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.
5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

The above "Notice to Applicant" was delivered to me on:

Date

Witness _____

Writing Agent

Applicant's Signature