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

Group name _____ Group # _____ Is this a Section 125? ☐ Yes ☐ No

D. Prior or other coverage

		APPLICANT YES	APPLICANT NO	SPOUSE YES	SPOUSE NO
1.	Is the insurance applied for here intended to replace any existing or pending dental insurance?	☐	☐	☐	☐

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?	☐	☐	☐	☐

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 and any medical information reviewed by Loyal, (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*.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act and may be subject to civil and criminal penalties.

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. 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 binding arbitration governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association. 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. By signing this application, I acknowledge that I am giving up the right to a trial in court, both with and without a jury.

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)*

F. Agent use only

I certify that I have provided the Primary Applicant with the following documents:

a. Application packet b. Outline of Coverage c. Other _____

I certify that I have interviewed the Primary Applicant, asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Primary Applicant. ☐ Check box if Agent family business

If you would like level commissions to be paid on this policy, check this box ☐; otherwise, heaped commissions will be paid. If you are a Licensed Only Agent (LOA), check with your management before requesting level commissions. Please refer to your commission schedule for heaped and level commission rates.

Printed name of licensed Agent	Signature of licensed Agent	Writing number	Percentage
Printed name of 2nd licensed Agent		Writing number	Percentage