



Application

Protection SeriesSM –

Dental, Vision and Hearing Insurance Plan

Policy Form CLIDH917

Underwritten by

**Continental Life Insurance Company
of Brentwood, Tennessee**

An Aetna Company

aetnaseniorproducts.com



**Continental Life
Insurance Company
of Brentwood, Tennessee**

An Aetna Company

P.O. Box 14399
Lexington, KY 40512

800 264.4000
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Dental, Vision and Hearing Insurance Plan

from Continental Life Insurance Company
of Brentwood, Tennessee

Page 1 of 5

- Print clearly and use blue or black ink.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

Please select one: New business
 Reinstatement *Policy number*

1. Proposed insured information

Go paperless! To receive your policy documents online, select "electronically" and provide your current e-mail address in Section 1. You will not receive paper policy documents, but instead, will receive an e-mail with a link to access them on our secure website.

Full name of proposed insured *First, M.I., Last (Must be oldest applicant)*

 Address Phone

 City State Zip

 E-mail Social Security Number

 Birth date *mm/dd/yyyy* Age Male
 Female

Additional proposed insureds

Domestic partner means your domestic partner as defined by applicable law.

Additional proposed insureds include spouse, domestic partner and unmarried child(ren) under age 26

Full name of spouse (or domestic partner) <i>Print</i>	Social Security Number
.
Birth date <i>mm/dd/yyyy</i>	Age <input type="radio"/> Male
. <input type="radio"/> Female
Full name of child <i>Print</i>	Social Security Number
.
Birth date <i>mm/dd/yyyy</i>	Age <input type="radio"/> Male
. <input type="radio"/> Female
Full name of child <i>Print</i>	Social Security Number
.
Birth date <i>mm/dd/yyyy</i>	Age <input type="radio"/> Male
. <input type="radio"/> Female
Full name of child <i>Print</i>	Social Security Number
.
Birth date <i>mm/dd/yyyy</i>	Age <input type="radio"/> Male
. <input type="radio"/> Female
Full name of child <i>Print</i>	Social Security Number
.
Birth date <i>mm/dd/yyyy</i>	Age <input type="radio"/> Male
. <input type="radio"/> Female

If additional space is needed, please use a separate sheet of paper and attach to the application.

Policy delivery *(For agent use only; select one):*
 Agent: Mail
 Applicant: Mail Electronically

Application for Dental, Vision and Hearing Insurance Plan

Page 2 of 5

2. Benefits information

Requested effective date: -

Coverage type:

Individual Individual and spouse (or domestic partner) Individual and child(ren) Family

Dental, Vision and Hearing

DVH benefit amount

Premium amount

Policy form CLIDVH917

\$1,000

\$..... (annual)

\$1,500

\$2,000

3. Replacement questions

To the best of your knowledge:

Do you have any other health insurance in force? Yes No

If so, with what company, and what plan do you have?

Type of coverage Policy number

.....

Company

.....

Type of coverage Policy number

.....

Company

.....

Is the policy being applied for intended to replace any other insurance? Yes No

Type of coverage Policy number

.....

Company

.....

4. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 days greater than the policy's paid to date will draft a month in advance.

Proposed insured's name

.....

Account owner name, if different than proposed insured's

.....

Account owner relationship to proposed insured: Business owned Living trust Employer

by proposed insured Power of attorney Conservator/guardian

Family member; specify

.....

Financial institution name

.....

Checking Savings

.....

Routing number

.....

Account number

.....

Requested EFT draft date for ongoing premium payments (if different from initial premium draft date)

.....

5. Payment options

Initial premium:

Draft initial premium upon policy approval Draft initial premium on policy effective date

Premium mode:

Annual Semi-annual Quarterly Monthly bank draft (electronic funds transfer)

Payment method:

Check Electronic funds transfer List Bill billing file identifier

Premium collected:

\$

Payment options *continued*

PAYMENT MODES

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly bank draft). Each payment mode, other than annual and monthly bank draft, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates.

The annual and monthly bank draft modes have the same total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You have the right to change your payment mode, among the modes available, during the life of your policy.

6. Applicant agreement

I hereby apply to Continental Life Insurance Company of Brentwood, Tennessee for a Dental, Vision and Hearing Insurance Policy to be issued solely and entirely in reliance on the information provided on this application. I have read or had read to me the completed application and understand all statements and answers and certify that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for, and if 65 years of age or older, A Guide to Health Insurance for People with Medicare and a Non-Duplication of Medicare Disclosure.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if the information that is material to the acceptance of this application is incorrect, incomplete or untrue, Continental Life Insurance Company of Brentwood, Tennessee may adjust my premium or reduce my benefits.

I understand that this policy provides supplemental health insurance.

Applicant signature

Date signed

X

.

Dated at city/state

.

7. Privacy notice

Although your application is our initial source of information, we may collect information, including health history and medical records, from persons other than you and we may conduct a telephone interview with you. Continental Life Insurance Company of Brentwood, Tennessee, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

8. Agent

All information **must** be completed.

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant to review or was read to them and the applicant has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy.
3. I have provided an outline of coverage for the policy applied for, and if 65 years of age or older, *A Guide to Health Insurance for People with Medicare* and a Non-Duplication of Medicare Disclosure to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name *Printed*

Writing number (agent or company)

.

.

Agent signature

State license ID number (for FL only)

X

.

Phone

E-mail

.

.

9. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through Continental Life Insurance Company of Brentwood, Tennessee (CLI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with CLI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective CLI commission schedule.

Agent information *Print*

Writing agent		Percentage
.....	 %
Secondary agent	Writing number	Percentage
..... %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing agent signature

X
.....

10. Fraud warnings

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or combination thereof.

Arkansas and Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of the insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: 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.

Kentucky: 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 commits a fraudulent insurance act, which is a crime.

Maine and Tennessee and Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or a deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Pennsylvania: 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, which is a crime and subjects such person to criminal and civil penalties.



**Continental Life
Insurance Company
of Brentwood, Tennessee**

An Aetna Company

P.O. Box 14399
Lexington, KY 40512

800-264-4000
aetnaseniorproducts.com
office hours 7:00 a.m. - 7:00 p.m. CST

Initial premium receipt

from Continental Life Insurance Company
of Brentwood, Tennessee

Page 1 of 1

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.
- Be sure that all required sections of the application are completed. Any incomplete or missing information could delay processing of your application.

Initial premium receipt

Applicant name <i>Printed</i>	Date of application <i>mm/dd/yyyy</i>
.....
Electronic funds transfer (EFT) draft amount	Initial modal premium collected/drafted
\$	\$
Electronic funds transfer (EFT) draft date	
.....	

This acknowledges receipt of the initial premium in connection with your application for a Continental Life Insurance Company of Brentwood, Tennessee insurance policy.

Agent name <i>Printed</i>	Phone
.....

Signature of agent

X

- Payment will be refunded for any coverage not issued.
- A recorded telephone interview may be necessary as part of the underwriting on your application for insurance.
- All premium payments must be made payable to Continental Life Insurance Company of Brentwood, Tennessee.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.

A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant(s); and B. if the answers are true and correct in the application and if Continental Life Insurance Company of Brentwood, Tennessee issues a policy according to its rules, limits, and standards for the plan and amount applied for by the applicant(s); then this payment shall be applied to the payment of the first premium of the issued policy. No policy shall be effective until it has actually been issued by Continental Life Insurance Company of Brentwood, Tennessee.

**Thank you for choosing
Continental Life Insurance Company of Brentwood, Tennessee!**