❑ New Application
❑ Reinstatement
❑ Policy Change

CENTRAL UNITED LIFE INSURANCE COMPANY

10777 Northwest Freeway, Houston, TX 77092
Dental, Vision, and Hearing Insurance Application

Employee of What Department: _____

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 maybe committing a fraudulent insurance act, which is a crime.

APPLICANT INFORMATION

Name (Last, First, Middle Initial)	Date of Birth	Height	Weight	Gender (M/F)

Address (Street, City, State, ZIP Code)

Telephone Numbers (Home, Work, and Cell)	Email Address

Social Security Number	Employer	Hire Date	Type of Business

Applicant's Current Occupation

Requested Effective Date (optional):	Mail Policy To: ❒ Insured ❒ Agent

DEPENDENT(S) INFORMATION

Name (Print Full Name)	Social Security Number	Gender (M/F)	Date of Birth	Height	Weight (Lbs.)

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) Policy Year Maximum: ❑ $1,000 ❑ $1,500 Premiums: _____

EMAIL CONSENT AUTHORIZATION

❒ I give my written consent to allow Central United Life Insurance Company (the 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: _____

Mother's Maiden Name in Lieu of 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

1. Does the applicant have existing dental, vision, or hearing coverage? . . . . . ❑Yes ❑ No
2. To the best of your knowledge, will the insurance applied for replace existing insurance contract or policy in any company(s)? . . . . . ❑Yes ❑ No
3. If a replacement(s), and if state regulations require it, have you:
   a. Given "Notice to Applicant Regarding Replacement of Insurance"? . . . . . ❑Yes ❑ No
   b. Completed replacements forms, if required in your state? . . . . . ❑Yes ❑ No
   c. Have you complied with state regulations on disclosure? . . . . . ❑Yes ❑ No

All information recorded by me on this application is true and accurate to the best of my knowledge.

Agent No.	Soliciting Agent Signature	Date
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 the 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).

Check on of the following regarding your eligibility for Medicare, and "A Guide to Health Insurance for People with Medicare."

❑ 1. I have agreed to accept a link to the Medicare Buyer's Guide on the Company website.
❑ 2. I have received a hard copy of the Medicare Buyer's Guide.
❑ 3. I am not eligible for Medicare.

CAUTION: If your answers on this application are fraudulent, 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 CUL. 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 HOME OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED. THE POLICY WILL BECOME EFFECTIVE WHEN ALL UNDERWRITING REQUIREMENTS HAVE BEEN SATISFIED AND PREMIUMS PAID.

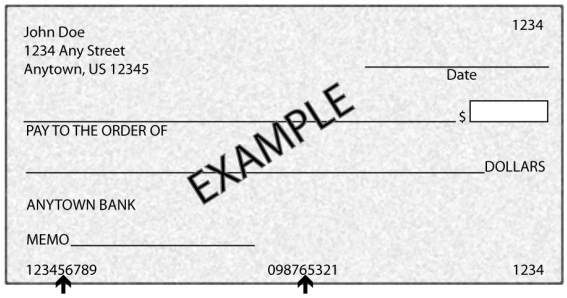
_____
Mother's Maiden Name in Lieu of Signature

_____ _____
Signed At (City/State) Dated (Day/Month/Year)

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 Central United Life Insurance Company beginning with the month of _____, 20_____ , a deduction of $_____ each month.
Mother's Maiden Name_____ Date_____
In Lieu of Signature



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 Central United Life Insurance Company, hereinafter called 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 Name as it appears on Bank Records Mother's Maiden Name in Lieu of Signature Date

❑ Credit Card Payment: ❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

Type of Card: ❒ VISA ❒ MasterCard
Credit Card Number_____ Expiration Date_____ CVC Code_____
AGREEMENT: I the undersigned, request and authorize You to make charges to my credit card specified above for payment of policy premiums. This authorization will 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 debit. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of and rights in respect to each such charge shall be the same as if it were signed by me. I further agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. The information above has been completed and this form signed and dated signifying acceptance of this transaction.
Name as Shown on Credit Card_____
Mother's Maiden Name in Lieu of Signature _____ 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:_____

To submit this application automatically via email, click the link below.
Or save it to your computer and email it to debbie@americanbenefitsinsurance.net

SUBMIT APPLICATION