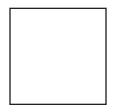


United National Life Insurance Company of America 1275 Milwaukee Avenue Glenview, Illinois 60025 (800) 207-8050



Dental Shield 2.0 Application for: Limited Benefit Policy Providing Dental Coverage DELIVER DOCUMENTS TO: O AGENT O INSURED

Applicant 1							
First Name			M.I	_ Last Nar	ne		
Soc. Security #		Age	Date of Birth	/_	/	_ O Male	O Female
Phone ()	_ O Mobile	E-mail Address	<u> </u>				
Applicant 2 /Spouse							
First Name			M.I	_ Last Nar	me		
Soc. Security #		Age	Date of Birth	/_	/	_ O Male	O Female
Phone ()	_ O Mobile	E-mail Address	5				
Child 1							
First Name			M.I	_Last Nar	ne		
Soc. Security #		Age	Date of Birth	ı/_	/	_ O Male	O Female
(For additional dependents, pinformation for each dependent		a separate piece	of paper, signed	l by the Ap	oplicant 1	, including t	he above
Address							
Home Address			City		Stat	te Zip	
enefit Option Selection		Applicant 1			A	pplicant 2	
Choose an Annual Maximum Benefit Amount:	O \$1,000	0 0 \$2,000 0	\$3,000	0 \$		\$2,000	O \$3,000
ptional Riders							
Child Rider (Benefit level will be the same as Applicant 1)		0					
Premium Payment Mode	O Annual	O Semi Annual	O Quarterly C	Monthly	Bank Dra	aft	
Modal Premium (Includes an Annual \$20 Policy Fee)	Applicant	1 Total Premium	\$	Applic	cant 2 Tot	al Premium	\$
equested Effective Date:/_	/		,				
equested Effective Date cannot be n the date approved by underwriti		Application Date	e. If no Effective	Date is re	quested,	the policy v	will be effec
equested Draft Date://							

Select Billing Day

OR: O 2nd Wednesday O 3rd Wednesday O 4th Wednesday

Replacement of Coverage		Applicant 1	Applicant 2
Will this policy replace any existing insurance with any company? and type of insurance below and submit a Replacement Form i	O Yes O No	O Yes O No	
lf "Yes", with which company and what type of insurance? (Ap	plicant 1)		
lf "Yes", with which company and what type of insurance? (A	pplicant 2)		
Acknowledgement & Authorization THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE)	SUBSTITUTE FOR MAJOR M	IEDICAL COVERAC	GE. LACK OF MAJOR
APPLICANT ACKNOWLEDGEMENTS			
I hereby apply to United National Life Insurance Company of America (in this application for insurance coverage ("Application"). I have read statements made in this Application and all answers to the question of my knowledge and belief. I understand that innocent, negligent o could result in a reduction of benefits or denial of an otherwise valid changes in my health conditions, from the date of this Application of coverage. No agent or other representative of UNL has required, provided any conditions of this Application. I acknowledge I have received the Outline of Coverage, (2) Notice of Privacy Practices, (3) the Pre-Nand (3) A Guide to Health Insurance for People with Medicare and the	or had read to me the comples contained in the Application or fraudulent (i) omissions, (ii) not claim, or rescission of the insuntil insurance becomes effect or mitted, or encouraged me ved or will receive the following lotice which describes how into	eted Application and are full, completed in are full, completed in a service coverage. It is an away result in to answer any query in conjunction with a service complete in conjunction with a service complete in conjunction is obtain are services.	nd I represent that all and true, to the best or (iii) misstatements understand that any the declination of my estion inaccurately or ith my Application: (1), ed and used by UNL,
Electronic Transactions, Electronic Signatures, Policy Fulfillmen	t and Communications		
This Application may be completed by electronic device or telephor accordance with any applicable federal or state law and that if this Ap and authorization to complete an electronic transaction to apply fo same effect as if I had physically signed this Application. If this Applic to accept my voice signature response as having the same effect as Policy and other UNL communications electronically. I also acknowle which describes the requirements for Electronic Policy Fulfillment a Fulfillment and Communications and receive a paper copy of my Po	plication is completed by electr r this coverage. My electronic cation is completed by telepho if I had physically signed this A dge receipt of the Electronic D nd Communications, as well as	onic means, I have signature is legally nic means, I autho pplication. I agree elivery and Commu	provided my consent binding, and has the rize UNL or the agent that I may receive my unications Disclosure,
Fraud Notice: Any person who knowingly and with intent to de for insurance containing any materially false information or c thereto commits a fraudulent act, which is a crime and may be	onceals, for the purpose of	misleading, any	information or fact
Applicant 1 Signature:	Date:		
Signed at: City and State:			
Applicant 2 Signature:			
Signed at: City and State:			
Agent's Statement			
I certify that I have accurately recorded the information suinformation which may have a bearing on the insurability of supplement to it. I have advised the applicant not to withhold I have advised the application for conthey are notified in writing by United National Life Insurance	f anyone proposed for ins d any information relative t npleteness and accuracy a	urance on this a o this applicatior	pplication and any and its questions
Agent's Name (Printed)	E-mail Address	Agent	Code
Agent's Signature		Dat	

-	Authorization Premium Payme Honor Withdrawals to be drawn by		nce Company of Am	erica.	
TO	The second secon	511100 1 100101101 2 110 1110011	ee e epa, e,	o. 10d.	
Name of my Bank		My Bank's Address	City	State	Zip Code
	e to me, I request and authorize yo ited National Life Insurance Compa presentation.				
Bank Routing #:		Account #:			
Account Type	O Checking Account (Attach a Vo	oided "Sample" check)			
	O Savings Account (Attach a Void	ded "Sample" check if app	licable, or a Deposit	slip)	
me. This autho will be fully pro without cause	rights in respect to each payme rity is to remain in effect until revo tected in honoring such requests and whether intentionally, or inac feiture of insurance.	oked by me in writing an . I further agree that if a	d until you receive r ny such payment is	notice for which not honored, v	n you agree you whether with or
Printed nam	e of insured if different from premi	um payer Premium	n payer's signature, a	s it appears on	bank records

	Detach the below Notice to Applicant and Receipt and leave with applicant
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NOTICE TO APPLICANT – PARTS 1 AND 2

Part 1: Fair Credit Reporting Act and Privacy Act Pre-Notification

The application you completed for insurance with us, in most cases, gives us all the information we need. In certain cases, we may need more information.

If we need more information, we may get it by talking to other persons you know including, but not limited to, your agent or other insurance companies you have applied to. We may ask an independent "consumer reporting agency" to help us verify facts or get additional facts.

We may collect information concerning your health, job and financial situation, as well as your character, general reputation and mode of living. We will not collect information relating to your sexual orientation.

The personal information we obtain about you is treated as confidential and will not be discussed to other persons or organizations without your written authorization except to the extent necessary as permitted by law, for the conduct of our business. But any information collected by a "consumer reporting agency" may be shared by the agency with others who use such information, but only to the extent which the Fair Credit Reporting Act Permits. You have a right of access, and right of correction, concerning recorded personal information obtained in our file. In order to exercise these rights, you must contact us in writing requesting access or correction.

You have no access right to privileged information. If we used a "consumer reporting agency," you have the right to: (1 ask to talk with them and (2) ask them about their report. You may write us for the name and address of the agency. This paragraph is not intended as a complete description of your right of access and correction. If you would like a more complete description of our insurance information and Privacy Protection Practices, please write: United National Life Insurance Company of America, 1275 Milwaukee Avenue Glenview, IL 60025.

Part 2: Notification Regarding MIB, Inc.

Information regarding your insurability will be treated as confidential. United National Life Insurance Company of America or its reinsurers may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc., will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the MIB, Inc. information office is 50 Braintree Hill Park, Suite 400, Braintree Massachusetts 02184-8734, telephone number (866) 692-6901, e-mail address infoline@mib.com. United National Life Insurance Company of America or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

		- — — — — — — — — — — — — — — — — — — —
	the sum of \$ ny reason the application is declined this paym und of this payment, until the insurance applied	
Agent's Signature		

If you do not receive your policy within 60 days from the date of your application, please write to: United National Life Insurance Company, 1275 Milwaukee Avenue, Glenview, IL 60025

MAKE CHECK PAYABLE TO:
UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA