Application

Protection Series℠–

Dental, Vision and Hearing Plus Insurance Plan

Vermont

Policy form CLIDVH20 VT

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

AetnaSeniorProducts.com

Application for Dental, Vision and Hearing Plus Insurance Plan

- Print clearly and use blue or black ink.
- Mail application and check in the provided business reply envelope.
- Complete all required sections of the application. Any incomplete or missing information could result in delay or closure of your application.

Select one: ☐ **New business** ☐ **Reinstatement** Policy number •

Section 1a. Proposed insured's information

Proposed insured's name (must be oldest applicant) *(first, M.I., last)* •

Phone •

Residential address •

Apt/suite number •

City •

State •

Zip •

Mailing address *(if different than residential address)* •

Apt/suite number •

City •

State •

Zip •

E-mail •

Social Security Number •

Birth date *(mm/dd/yyyy)* •

Age •

☐ **Male**
☐ **Female**

Policy delivery method: ☐ Mail to applicant ☐ Mail to Agent ☐ Electronic delivery to applicant

To receive documents electronically, please provide your email address in Section 1a, and we'll email you instructions on how to opt in. You may opt out of electronic delivery of documents at any time.

Section 1b. Additional proposed insureds

Additional proposed insureds include spouse, domestic partner and unmarried child(ren) under age 26. Domestic partner means your domestic partner as defined by applicable law.

Spouse/domestic partner name *(first, M.I., last)* •

Social Security Number •

Birth date *(mm/dd/yyyy)* •

Age •

☐ **Male**
☐ **Female**

Child name *(first, M.I., last)* •

Social Security Number •

Birth date *(mm/dd/yyyy)* •

Age •

☐ **Male**
☐ **Female**

Child name *(first, M.I., last)* •

Social Security Number •

Birth date *(mm/dd/yyyy)* •

Age •

☐ **Male**
☐ **Female**

Child name *(first, M.I., last)* •

Social Security Number •

Birth date *(mm/dd/yyyy)* •

Age •

☐ **Male**
☐ **Female**

Attach an additional sheet of paper if needed.

Section 2. Benefit and premium information

Requested effective date* *(mm/dd/yyyy)*

•

Coverage type

☐ Individual ☐ Individual and spouse/domestic partner ☐ Individual and child(ren) ☐ Family

Benefit amount

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

Premium amount

$

Initial premium

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

Total initial premium collected/draft

$

Payment mode

☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

Payment method

☐ Check ☐ Electronic Funds Transfer ☐ List bill Billing file identifier:

*Unless otherwise requested, the effective date is the application signature date as long as the application is received at the administrative office within 15 days.

**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.

Payment modes

You have a choice of four payment modes for paying your premium. The Company may charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in available modes and methods and help you decide which is best for you. EFT is an available premium payment method for all payment modes, but EFT is the only premium payment method available for the Monthly payment mode.

Section 3. Replacement questions

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

Type of coverage	Policy number	Company
•	•	•
Type of coverage	**Policy number**	**Company**
•	•	•

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

Type of coverage	Policy number	Company
•	•	•

Section 4. Account information

Complete this section **if you are requesting electronic funds transfer (EFT)** for premium payment. Include a voided check with the application.

Proposed insured's name

•

Account owner name *(if different than proposed insured's)*

•

Account owner relationship to proposed insured

☐ Business owned by proposed insured ☐ Living trust ☐ Employer

☐ Power of Attorney ☐ Conservator/guardian ☐ Family member; please specify:

Financial institution name

•

Account type

☐ Checking ☐ Savings

Routing number

•

Account number

•

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

•

Section 5. Applicant agreement

This agreement is to acknowledge that I am applying for an insurance policy from Continental Life Insurance Company of Brentwood, Tennessee that will be issued based on the information provided on this application. I have read, or had read to me, the completed application, understand all statements and answers, and acknowledge that to the best of my knowledge and belief, they are all accurate, complete, and correctly documented. I understand that I will receive a copy of the signed application. I acknowledge that I have received an outline of coverage for the policy that I applied for, and, if 65 years of age or older, a copy of Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare and a Non-Duplication of Medicare Disclosure.

I understand and agree that this application and any policy issued will be the entire contract of insurance.

The Company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the Company's administrative office, and made a part of the contract of insurance. An Officer of the Company is the only one who can make, modify or discharge contracts or waive any of the Company's rights or requirements; and any modifications must be documented in writing.

I also understand that I do not have coverage until this application is approved, the first premium is paid, and a policy has been issued by the Company.

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 any answers on this application are 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

X

Date signed

•

Dated at *(city, state)*

•

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Section 6. 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.

Section 7. Agent information

I certify that:

1. I have truly and accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant(s) to review 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 *A Guide to Health Insurance for People with Medicare* to applicant prior to completing the application.

All information must be completed. The writing number reflects where commissions will be paid.

Agent name *(printed)*

•

Agent signature

X

Writing number *(agent or company)*

•

State license ID number *(for FL only)*

•

Phone

•

Email

•

Section 8. Agent request 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 in force.
- 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.

Writing agent name *(printed)*

•

Percentage

• %

Writing agent signature

X

Secondary agent

•

Writing number

•

Percentage

• %

This section must be completed with this application in order to split commissions. By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

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Continental Life Insurance Company of Brentwood, Tennessee
An Aetna Company

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

Applicant receipt

Thank you!

- Applicant keeps this receipt for their records.

- Payment will be refunded for any coverage not issued.
- 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.

Applicant name *(printed)*	**Date of application**
•	•
Initial payment collected *(if applicable)*	**Payment type**
$	☐ Check ☐ Money order
EFT draft amount	**EFT draft date**
$	•

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

Agent name *(printed)*	**Agent signature**
•	**X**
Phone	**Email**
•	•

A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant; 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!