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Application

Protection Series℠ –

Dental, Vision and Hearing Insurance Plan

Policy Form CLIDH917

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

aetnaseniorproducts.com

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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

- 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) *Print* | Social Security Number

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

Full name of child *Print* | Social Security Number

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

Full name of child *Print* | Social Security Number

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

Full name of child *Print* | Social Security Number

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

Full name of child *Print* | Social Security Number

Birth date *mm/dd/yyyy* | Age | ○ Male ○ 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

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 ○ $1,500 ○ $2,000	$..... (annual)

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 by proposed insured ○ Living trust ○ Employer ○ 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

X

Date signed

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.

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Health information authorization

800-264-4000
aetnaseniorproducts.com

- Please read these statements carefully. Print clearly using blue or black ink.
- This is a HIPAA required authorization.
- Applicant / insured must submit a completed, signed copy to the home office.
- Applicant / insured should keep a copy for their records.

Applicant / insured declarations

I authorize the use and disclosure of health information about me as described below.

Health Information to be Used or Disclosed: I understand this authorization applies to information about my past, present or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to, my prescription history, diagnoses and treatment for illnesses, medical conditions, mental illness, substance abuse and tobacco use, but excluding psychotherapy notes and information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Aetna and the members of its Affiliated Covered Entity ("Aetna ACE"). An Affiliated Covered Entity is a group of Covered Entities under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the Aetna ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the Aetna ACE and as permitted by HIPAA and this authorization; Aetna ACE's insurance support organizations and reinsurers; providers, treatment facilities, insurers, pharmacies, pharmacy benefit managers and consumer reporting agencies.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, mental health and substance abuse counselors and other health professionals; treatment facilities including hospitals, clinics, substance abuse treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities, reinsurers, other insurance companies and consumer reporting agencies.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of Aetna's life and health insurance plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization and that a copy of it is as valid as the original; (2) this Authorization is valid for 24 months from the date signed; (3) if I do not sign this Authorization or I revoke it by writing to Aetna at its administrative office, my application may be declined; (4) if I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization; and (5) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Applicant / insured complete this section.

Signature of applicant / insured — Date

X .

Printed name of applicant / insured

X

City — State — Zip

. . .

Policy number of insured (if known)

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