LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271 M/S E8L
Portland, OR 97207-1271
(800) 756-4105

Home Office Use Only
ID #
Eff. Date
Vis. Rider ☐ EFT ☐

RENEWABLE INDIVIDUAL DENTAL INSURANCE APPLICATION (WITH OPTIONAL VISION RIDER)

Please Note: This Policy provides dental benefits only. The Policy provides vision benefits only if elected.

Please complete all information on this page and on Page 2. Incomplete information may result in a delayed Effective Date.

Applicant's Last Name	Applicant's First Name	M.I.	☐ M ☐ F	Date of Birth (mm/dd/yyyy
Social Security Number	☐ Married ☐ Divorced ☐ Single		E-mail Address	
Mailing Address: Street Address & Apt. No. City		State	Zip	Telephone Number ( )

Requested Effective Date

Your requested Effective Date must be following or coinciding with the date We receive your Application, after the date your Application is signed, and within 60 days from the date of your signature, or a new Application will be required.
A new Application may result in a delayed Effective Date. In no event may the Effective Date of this Policy be back-dated

☐ 1st OR ☐ 15th of ____________________ (month) _____________ (year)

Dependents to be enrolled: Dependent children must be under 26 years of age.

Name (Last, First, M.I.)	Social Security Number	Birth Date	Sex	Relationship To You
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

Please list names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.

Other coverage information (This is not a waiver of coverage. This information is required for payment of claims.)
Do you or any family members enrolling have other dental coverage? ☐ **Yes** ☐ **No**
If yes, provide the information regarding other coverage requested below.

Name of Family Member with other coverage		Relationship
Name of Insurance Carrier	Policy No.	ID No.
Address of Other Carrier City State Zip		Carrier Phone No. ( )
This plan covers ☐ Self ☐ Spouse ☐ Child(ren) ☐ Family as listed above ☐ Other ______________________ (check all that apply)		Termination Date (if applicable)
Is the coverage of any dependent affected by a divorce decree/court order? ☐ Yes ☐ No If yes, please include portion of decree that shows responsibility for health expenses.		

You may enroll for Dental Only Coverage or Dental with Vision Coverage.
All members must be enrolled for the same coverage and premium payment schedule.

I am making application for:

☐ **DOLLAR-BASED DENTAL INSURANCE**

NOTE: This coverage has a **6 MONTH BENEFIT WAITING PERIOD (BWP)*** for **ALL SERVICES**.

☐ **INCENTIVE 10 DENTAL INSURANCE**

NOTE: This coverage has a **6 MONTH BWP*** for **RESTORATIVE SERVICES and a 12 MONTH BWP* for MAJOR SERVICES**

*The **BENEFIT WAITING PERIOD** is the continuous length of time the member must be covered under the Policy before becoming eligible for benefits.

Add Vision Rider ☐ Yes ☐ No **Premium Payment Schedule:** ☐ **Monthly** ☐ **Quarterly**

Premium Calculation

	Number enrolling for coverage		Enter Monthly or Quarterly Dental Only or Dental with Vision Premium Rate		
Under Age 18	____________	X	$ ______________________	=	$ ______________________
Age 18 through age 64	____________	X	$ ______________________	=	$ ______________________
Age 65 and over	____________	X	$ ______________________	=	$ ______________________

Total Monthly or Quarterly Dental or Dental with Vision Premium Rate **$** ______________________

Your 1st premium payment must be enclosed with this Application.

	Total Monthly or Quarterly Dental or Dental with Vision	$ ______________________
PLUS	Policy Fee of	$ 25.00
Equals	**Total Due**	**$** ______________________ **(Enclosed)**

I hereby apply for enrollment with LifeMap Assurance Company (LifeMap) under the Individual Dental Insurance plan.

I acknowledge and understand LifeMap and the Participating Provider may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

DISCLOSURE: If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from LifeMap. Incentives may be based on any of several factors including the products you buy, your broker or agent's volume of business with LifeMap and the other services your agent or broker provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

INSURANCE FRAUD WARNING: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all entitlements to benefits are void and the contract may be canceled or modified retroactively to its effective date.

▶ ____ ____

Insured's Signature Parent's or Guardian's Signature

▶ ____________________ ____________________ ____

Date Signed Insurance Producer Number Insurance Producer Name (Please Print)