The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, OH 43215
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 800.948.1039 • www.uct.org

APPLICATION FOR DENTAL AND VISION INSURANCE POLICY

Requested Effective Date of Policy:

APPLICANT

Last *First* *MI*

AGE	DATE OF BIRTH			SEX
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

APPLICANT'S ADDRESS

Street: _____

City: _____

State: _____ **Zip Code:** _____

Area Code: _____ **Telephone Number:** _____

Email Address: _____

OWNER *(if applicant is a minor)*

Last *First* *MI*

Area Code: _____ **Telephone Number:** _____

Email Address: _____

OWNER'S ADDRESS

Street: _____

City: _____

State: _____ **Zip Code:** _____

Are you a member of The Order of United Commercial Travelers of America? ☐ Yes ☐ No

Council Name: _____ Council Location (City & State): _____

Is anyone else who resides in your household also applying for the Dental and Vision Insurance Policy?
If yes, please complete. ☐ Yes ☐ No

Name _____ Name _____

Name _____ Name _____

(Please list any additional individuals on a separate paper and attach to the application.)

MEDICAL INFORMATION

	APPLICANT
1. Do you currently wear dentures?	☐ Yes ☐ No
2. Have you been advised to have any dental work which has not been completed?	☐ Yes ☐ No
If "Yes", provide details: _____	
3. Do you currently wear eyeglasses or contact lens?	☐ Yes ☐ No
4. Have you received advice or treatment within the past nine (9) months for correction of a vision problem?	☐ Yes ☐ No
If "Yes", provide details: _____	
5. Do you currently wear a hearing aid?	☐ Yes ☐ No
6. Have you been treated for hearing loss within the past nine (9) months?	☐ Yes ☐ No
7. Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?	☐ Yes ☐ No

BENEFIT OPTIONS	
Policy Year Maximum	☐ **$1,000** ☐ **$2,000** ☐ **$1,500** ☐ **$2,500**
Deductible Options	☐ **$0** ☐ **$100**
Rider Options	☒ **Hearing Rider (included)**

BILLING TYPE	MODE OF PAYMENTS
☐ **Individual** ☐ **Worksite**	☐ **Annual** ☐ **Semiannual** ☐ **Quarterly** ☐ **Monthly EFT** ☐ **List Bill**

Plan Premium

Hearing Rider Premium (If Applicable)

SUBTOTAL

Less Household Discount (If Applicable)

TOTAL MODAL PREMIUM

Modal Fraternal Dues (If Applicable)

TOTAL MODAL AMOUNT DUE **$ _____**

TOTAL AMOUNT PAID WITH APPLICATION **$ _____**
(if EFT, initial premium may be drafted)

REPLACEMENT INFORMATION (MUST BE COMPLETED)

APPLICANT

1. Do you have any dental or vision insurance currently in force? ..... ☐ Yes ☐ No
2. Is the insurance applied for intended to replace any existing insurance with this or any other company? ☐ Yes ☐ No

   If "Yes", with which company: (Name and address): _____

   _____

   Policy Number: _____ If that policy lapsed, when did it lapse? _____
3. If replacement is involved, have you received a replacement form (in states where required by law)? .... ☐ Yes ☐ No

APPLICATION AGREEMENT

I hereby apply to The Order of United Commercial Travelers of America (UCT) for a policy to be issued in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. I understand that any change in my health prior to delivery of this policy may be used in the underwriting evaluation process. I have received an outline of coverage for the policy applied for.

If not a current member of The Order of United Commercial Travelers of America, I apply to become a member as indicated by my signature below. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.

FRAUD WARNING: 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 a false or deceptive statement is guilty of insurance fraud.

_____ _____

Signature of Applicant **Date**

_____ _____

Signature of Owner (if applicant is a minor) **Date**

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____

_____

_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____

_____

_____

I certify that:
1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

Agent's Signature: _____ **Date:** _____

Agent's Printed Name: _____ **Agent No.:** _____

Agent's E-mail: _____

AUTHORITY TO HONOR PREMIUM CHECKS

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619

Name of Bank Customer: _____ **Type of Account:** ☐ **Checking**

Insured's Name: _____ ☐ **Savings**

Routing Number: _____ **Account Number:** _____

To (Name of Bank): _____

Address of Bank: _____

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to 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 check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America 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 forfeiture of insurance.

Date:	**Signature of Bank Customer:**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above: In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

ATTACH VOIDED CHECK HERE – Deposit Slips NOT Accepted

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by The Order of United Commercial Travelers of America. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____
(Signature of Agent, Broker or Other Representative)

_____
Print Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

_____ _____
(Applicant's Signature) **(Date)**

Where Community and Compassion Unite

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Print Name and Address of Agent

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DENTAL AND VISION EXPENSE INSURANCE POLICY

THIS IS A LIMITED BENEFIT POLICY WHICH ONLY PROVIDES BENEFITS FOR DENTAL AND VISION EXPENSES. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY. THIS POLICY WILL NOT COVER ALL OF YOUR MEDICAL EXPENSES.

OUTLINE OF COVERAGE POLICY FORM DV 0312

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and United Commercial Travelers of America. It is therefore important that you **READ YOUR POLICY CAREFULLY.**

Dental and Vision only coverage is designed to provide you with coverage for certain losses for dental and vision **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFIT PLAN OPTIONS

After the Policy Year Deductible is satisfied, the Company will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% in the first Policy Year;
2. 70% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Covered Expenses, subject to the Limitations and Exclusions, are:

Dental Benefits
We will pay the applicable percentage for fillings, non-routine X-rays and a maximum of (4) four simple extractions during the first Policy Year.

After the policy has been in force three (3) months, the Company will pay the first visit up to $125 for routine Dental Cleaning, Examination and X-ray. After the policy has been in force twelve (12) months, routine Dental Cleaning, Examination and X-ray are payable twice per year with up to $125/$75 alternating toward Preventative Dental Procedures. In the first policy year the amount payable up to the $125.00 benefit will be applicable. Beginning in the second policy year, the amount payable up to $125.00 will be applied to the first visit and up to $75 to the second visit. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit. Services performed by a licensed Dentist to include a routine examination, cleaning and x-ray.

After the policy has been in force twelve (12) months, We will pay the applicable percentage for dental services performed by a licensed Dentist to include bridges, crowns, full dentures or partials, “full mouth” extractions, and root canals.

Vision Benefits
We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any twenty-four (24) month period.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).

Limitations and Exclusions

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

We will NOT pay benefits during the first Policy Year (12 months) for the following items and/or services:

Bridges, crowns, full dentures or partials, "full mouth" extractions, and root canals.

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared; or
2. any intentionally self-inflicted Injury; or
3. any loss resulting from the commission of or the attempt to commit an assault or felony; or
4. any loss resulting from engaging in any illegal activity or occupation; or
5. any services that are not recommended by a Physician or other licensed medical professional; or
6. any Experimental or Investigational Procedure or Treatment; or
7. orthodontic treatment; or
8. implants; or
9. occlusal guards, adjustments; or
10. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
11. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed for the treatment of cataracts); or
12. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
13. prescription drugs; or
14. charges in excess of Reasonable and Customary Charges; or
15. treatment or diagnosis received while outside the United States of America or its territories; or
16. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
17. loss that occurs while this Policy is not in force.

RENEWABILITY. The policy is guaranteed renewable for life. We will renew the policy each time you send us a premium. It must be paid on or before the date it is due or during the 31 days that follow.

PREMIUM CHANGE. We may change the premium rates for the policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class and in the same state where your policy was issued.

FOR AGENT USE ONLY

Dental and Vision Insurance Policy Application Submission Checklist:

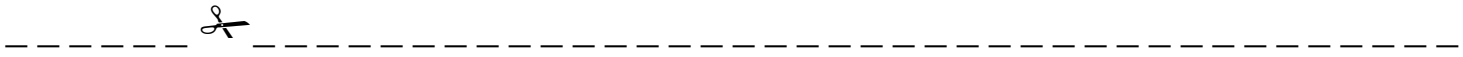
☐ Complete Application

☐ Collect premium amount (Please remember to include membership dues – a minimum of $30 annually, $15 semi-annually, $7.50 quarterly, or $2.50 monthly)

☐ Provide client with Outline of Coverage

☐ Complete Replacement Notice and leave copy with the applicant if necessary

☐ Provide client with Receipt



PREMIUM RECEIPT

Make check payable to UCT.

Received from _____ the sum of $_____.

If, for any reason, the policy is not issued, payment will be refunded in full in a timely manner. Insurance is not effective until the application is approved, the premium has been paid and the policy is issued.

Date: _____ Licensed Resident Agent: _____

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