MANHATTAN INSURANCE GROUP SM

Dental, Vision & Hearing Webinar

CENTRAL UNITED LIFE INSURANCE COMPANY SM

MANHATTAN INSURANCE GROUP SM

Since 1982

CENTRAL UNITED LIFE INSURANCE COMPANY SM

Since 1963

THE MANHATTAN LIFE INSURANCE COMPANY SM

Since 1850

FAMILY LIFE INSURANCE COMPANY SM

Since 1949

WESTERN UNITED LIFE ASSURANCE COMPANY SM

Since 1963

Dental Statistics

- 92% of adults 20 to 64 have had dental problems in their permanent teeth.
- 26% of adults 20 to 64 have untreated decay
- Only 57% of the total population have dental coverage.
- “Lack of insurance” is the most commonly cited reason for not visiting the dentist.

Source:
National Institute of Dental Research
NADP Joint Dental Report 2009

Dental Coverage

Preventive Services Semi-Annual exams, cleaning and x-rays.	**Year 1 - 60%** **Year 2 - 70%** **Year 3 and thereafter - 80%***
Waiting Period	**None**
**In OH, year 3 and thereafter is 70%*	
Basic Services Including x-ray (other than "full mouth"), fillings and extractions	**Year 1 - 60%** **Year 2 - 70%** **Year 3 and thereafter - 80%***
Waiting Period	**None**
**In OH, year 3 and thereafter is 70%*	
Major Services Including bridges, crowns, full dentures or partials, full mouth extractions, and root canals	**Year 1 - 0%** **Year 2 - 70%** **Year 3 and thereafter - 80%***
Waiting Period	**12 months**
**In OH, year 3 and thereafter is 70%*	

Vision Statistics

- 62% of adult population in the United States uses prescriptive eyewear, only 48% have a vision exam every year or less
- The number of visually impaired people likely will double by 2030 according to VisionWatch
- 1 out of 4 children have vision problems
- Eye exams help detect several preventable and treatable diseases such as: Glaucoma, high blood pressure and Diabetes.
  - Glaucoma is the leading cause of blindness in the United States.
  - Diabetics are 25 times more likely to become blind than non-diabetics

Source: EyeCareAmerica.org

Vision Coverage

Basic eye exam or eye refraction, including the cost of eye glasses or contact lenses	**Year 1 - 60%** **Year 2 - 70%** **Year 3 and thereafter - 80%***
Waiting Period	**6 months** on eyeglasses and contact lenses

**In OH, year 3 and thereafter is 70%*

Hearing Statistics

- Men are more likely than women to report having hearing loss
- Among adults aged 70 or older with hearing loss who could benefit from hearing aids, fewer than one in three (30%) has ever used them. Even fewer adults aged 20 to 69 (approximately 16%) who could benefit from wearing hearing aids have ever used them
- At present, health benefits plans rarely include coverage for hearing aids so that consumers pay for hearing aids as an out-of-pocket expense (or forego purchase entirely)
- No states mandate that private health benefits plans provide hearing aid coverage for adults, and only seven (7) mandate any kind of coverage for children

Source: NADP Joint Dental Report 2009

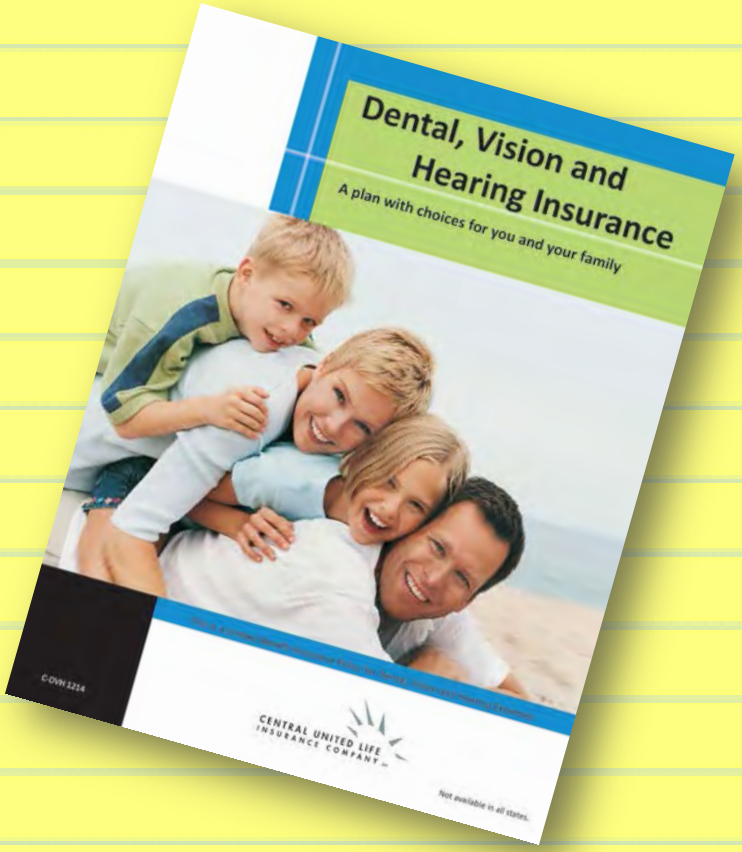
Hearing Coverage

Exam, hearing aid and necessary repairs or supplies	**Year 1 - 60%** **Year 2 - 70%** **Year 3 and thereafter - 80%***
Waiting Period	**12 months** new hearing aids and existing hearing aid repairs
**In OH, year 3 and thereafter is 70%*	

The Importance of DVH

Always a great door opener, "Who do you have your dental with?"
According to LIMRA, DVH is the #1 product asked for by customers.

- Prevent unforeseen situations that are painful, inconvenient and expensive!
- Protection of your client's savings
- Basic Medicare does NOT cover dental, vision or hearing expenses.
- Clients see the value of premium investment



Product Highlights

- Choose your dentist or service provider – *NO NETWORKS*
- Competitive Family Rates (Includes maximum of 3 children)
- Individual 18 – 75

Plan Benefits [1]	
Eligibility	Anyone age 18 - 75
Policy Year Maximum Benefit	**$1,000 or $1,500** (choose one)
Policy Year Deductible	$100 per person

Dental Coverage	
Preventive Services Semi-Annual exams, cleaning and x-rays.	**Year 1 - 60% Year 2 - 70% Year 3 and thereafter - 80%**
Waiting Period	**None**
Basic Services Including x-ray (other than "full mouth"), fillings and extractions	**Year 1 - 60% Year 2 - 70% Year 3 and thereafter - 80%**
Waiting Period	**None**
Major Services Including bridges, crowns, full dentures or partials, full mouth extractions, and root canals	**Year 1 - 0% Year 2 - 70% Year 3 and thereafter - 80%**
Waiting Period	**12 months**

- $1,000 - $1,500 policy year benefit option available
- Guaranteed Issue
- Guaranteed renewable to age 80.*

**Subject to our right to change premiums*

Vision Coverage	
Basic eye exam or eye refraction, including the cost of eye glasses or contact lenses	**Year 1 - 60% Year 2 - 70% Year 3 and thereafter - 80%**
Waiting Period	**6 months** on eyeglasses and contact lenses

Hearing Coverage	
Exam, hearing aid and necessary repairs or supplies	**Year 1 - 60% Year 2 - 70% Year 3 and thereafter - 80%**
Waiting Period	**12 months** new hearing aids and existing hearing aid repairs

[1] Refer to your policy for a complete description of limitations and exclusions.

Our Competitive Rates

[2] *Family rates include up to three children. Additional children are charged the age 3 - 17 rate per person.*

$1,000 Policy Year Maximum	
Age	**Premium**
3 - 17	$18.75
$1,500 Policy Year Maximum	
3 - 17	$24.75

$1,000 Policy Year Maximum

INDIVIDUAL MONTHLY PREMIUM	
Age	**Premium**
18 - 39	$25.00
40 - 54	$27.00
55 - 64	$29.00
65 - 75	$31.00

FAMILY MONTHLY PREMIUM[2]	
Age	**Premium**
18 - 39	$80.00
40 - 54	$84.00
55 - 64	$88.00
65 - 75	$92.00

$1,500 Policy Year Maximum

INDIVIDUAL MONTHLY PREMIUM	
Age	**Premium**
18 - 39	$33.00
40 - 54	$35.00
55 - 64	$38.00
65 - 75	$41.00

FAMILY MONTHLY PREMIUM[2]	
Age	**Premium**
18 - 39	$105.58
40 - 54	$109.58
55 - 64	$115.58
65 - 75	$121.58

Premiums are subject to change. Premium rates based on $1,000 or $1,500 Policy Year Maximum. Use the age of the oldest applicant. Benefit exclusions and limitations apply.

CENTRAL UNITED LIFE
INSURANCE COMPANY SM

Insured:
male35TX
Male, 35

Policy:
Health
Dental Vision Hearing

Agent:
HOME OFFICE
10777 NORTHWEST FWY
HOUSTON, TX 77092

Benefit Amount:
$1,500 per year

Breakdown of Benefit - Monthly EFT Premium:

Self - $1,500 per year	$33.00
Total Premium	$33.00

This is a Premium quote for a Limited Dental Vision Hearing policy. As the policyowner, you will pay the premiums. Coverage is guaranteed issue. The "Effective Date" of a policy will be the policy date stated on the policy schedule page. It is not the date the application is signed. Coverage may not be backdated. Guaranteed renewable until age 80, subject to the company's right to change premiums.

Dental, Vision and Hearing Insurance

A plan with choices for you and your family

This is a Limited Benefit Insurance Policy for Dental, Vision and Hearing Expenses.

John Doe
Office: 555-123-4567
Cell: 555-555-555
john.doe@email.com
www.JohnDoeWebsite.com

CENTRAL UNITED LIFE INSURANCE COMPANY

FAMILY LIFE INSURANCE COMPANY

Not available in all states.

C-DVH 0515

THIRTY¹-DAY RIGHT TO RETURN - Please read Your policy. If you are not satisfied for any reason, return the policy to the Company's Administrative Office or to Your Company sales Agent within 30¹ days after You receive it. As soon as You deliver or mail the policy to Us, it is treated as if it was never issued. We will (in LA, immediately) return your premium paid, less any claims paid. In OK only, If we do not return any premium or moneys paid within 30 days from the date of cancellation, We will pay interest on the proceeds.

¹In AZ, ID, IL, LA, MD, MO, OK, OH, PA and VA the right to return is 10 days.

PRE-EXISTING CONDITIONS - The Policy and any attached Rider(s) do¹ not cover Pre-Existing Conditions whether disclosed in the application or not, for the first 12 months (in NJ, 5 years) beginning on the date that person becomes an Insured on the Policy. IN MD, the Policy and any attached Rider(s), if any, do not cover Pre-Existing Conditions for the first 12 months beginning on the date that person becomes an insured on this Policy. In NC only, for any Insured over 65 years of age at the time the Policy is issued, Pre-Existing Conditions are only those conditions specifically eliminated by rider.

By Pre-Existing Conditions, We mean those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-months (in ID, OH and WY, 6 month) (in NJ, 5 year)period immediately preceding the Policy Effective Date. In MD, with respect to Pre-Existing Conditions disclosed in the application, this Pre-Existing Condition Limitation will not include a condition revealed on the application for coverage, unless the condition was excluded by a signed waiver rider attached to the policy. In NJ, congenital anomalies of a covered newborn child are not included in this definition of Pre-Existing Conditions. In PA, by Pre-Existing Conditions, We mean those conditions for which medical advice or treatment was received or recommended by a Physician within the 12-month period preceding the Policy Effective Date.

Except in ID, conditions specifically named or described as excluded in any part of the Policy are never covered.

¹ "any attached Rider(s) do" does not apply.

EXCLUSIONS AND LIMITATIONS - We will NOT pay benefits for the following items and/or services during the first six (6) months following the Policy Effective Date: 1. Eyeglasses or contact lenses.

We will NOT pay benefits for the following items and/or services during the first Policy Year: 1. endodontics (including root canals), periodontal surgery, bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions, fluoride treatments, or outpatient dental surgery; or, 2. hearing aids, including repairs. In MD, fluoride treatments does not apply.

We will NOT pay benefits for: 1. any loss resulting from war, declared or undeclared (in OK, while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntary or as required by an employer); 2. except in CA and IL, any intentionally self-inflicted injury (in CA, any willful and intentional act by the Insured to purposefully cause harm or damage to him/herself); 3. except in MD, any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation. In ID, any loss to which a contributing cause was your participation in a felony, riot or insurrection; 4. any services that are not recommended by a Physician; 5. except in MD, any Experimental or Investigational procedure or treatment; 6. orthodontic treatment or dental implants; 7. except in NM, any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state; 8. expenses incurred for surgical procedures (other than Medically Necessary outpatient dental surgery following the first Policy Year) (in MD, other than outpatient dental surgery, prescribed by a Physician, following the first Policy Year) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts). (In CA, MT, TX, VA, and WY, the reference to medical necessity does not apply. In VA, biennial periodontal surgery is not excluded); 9. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures (in CA, other cosmetic procedures does not apply); 10. impacted wisdom teeth; 11. occlusal guards; 12. prescription drugs; 13. treatment or diagnosis received while outside the territorial limits of the United States; 14. services for which you are not liable or for which no charge normally is made in the absence of insurance (In MD, other than benefits provided by Medicaid); and, 15. loss that occurs while this policy is not in force (in MD, subject to the Extension of Benefits Provision).

In MD only, prohibited health care practitioner referrals.

TERMINATION - All coverage under the Policy and any attached Rider(s) shall terminate when the Policy ceases to be in force.

The Policy will end¹ on the earlier of: a. when You fail to pay Premiums within Your Grace Period; or, b. except in IL, when You die; or, c. the Policy Anniversary Date You no longer meet the Renewal Condition as defined on the cover of the Policy. In IL, the date We receive a request in writing to terminate this Policy or on a later date that is requested by You for termination; or, d. the date You notify Us in writing to end the Policy.

In IL only, the end of the month You attain age 80; the date all Policies the same as this one are non-renewed or terminated in the state in which this Policy was issued or the state in which You presently reside. We will give You 90 days advance notice, as required by state law, of the termination of Your coverage; the date You move to a state where We do not provide insurance under a Policy with the same Policy design as this Policy, We reserve the right to terminate this coverage; or, the Insured performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

Coverage for an Insured Dependent will end on the date such Insured ceases to be an Eligible Dependent Child or Eligible Spouse², as defined in the Policy.

When such Insured's insurance ends, We will: a. consider any claim that began before the insurance ended; and, b. allow a conversion policy for an Eligible Dependent Child or Eligible Spouse², as set forth in the Conversion Privilege.

¹ In IL, at 12:01 a.m. local time at Your state of residence.

² In IL, Civil Union Partner; in CA and OR, Spouse or Domestic Partner; in MD, Eligible Covered Dependent, or Eligible Spouse/ Domestic Partner; in NJ, Eligible Spouse, Eligible Domestic Partner, or Eligible Civil Union Partner.

This brochure is designed to give a brief description of the policies and optional benefits and does not constitute a contract. The exact terms, limitations, definitions, conditions and qualifications of a specific procedure or service will be found in the policy delivered to you. The terms of the policy govern.

Policy Form Numbers: C-DVH, C-DVH-ID
C-DVH-LA, C-DVH-OK, CDVH-TX; F-DVH
(including state variations)

For more information contact:
JOHN DOE
Health Solutions
555-123-4567
abcdefg@emal.email

Underwritten by:
Central United Life Insurance Company
Family Life Insurance Company
10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone: 800-669-9030

FAMILY LIFE INSURANCE COMPANY

CENTRAL UNITED LIFE INSURANCE COMPANY

C-DVH-F 0615

Dental, Vision and Hearing Insurance

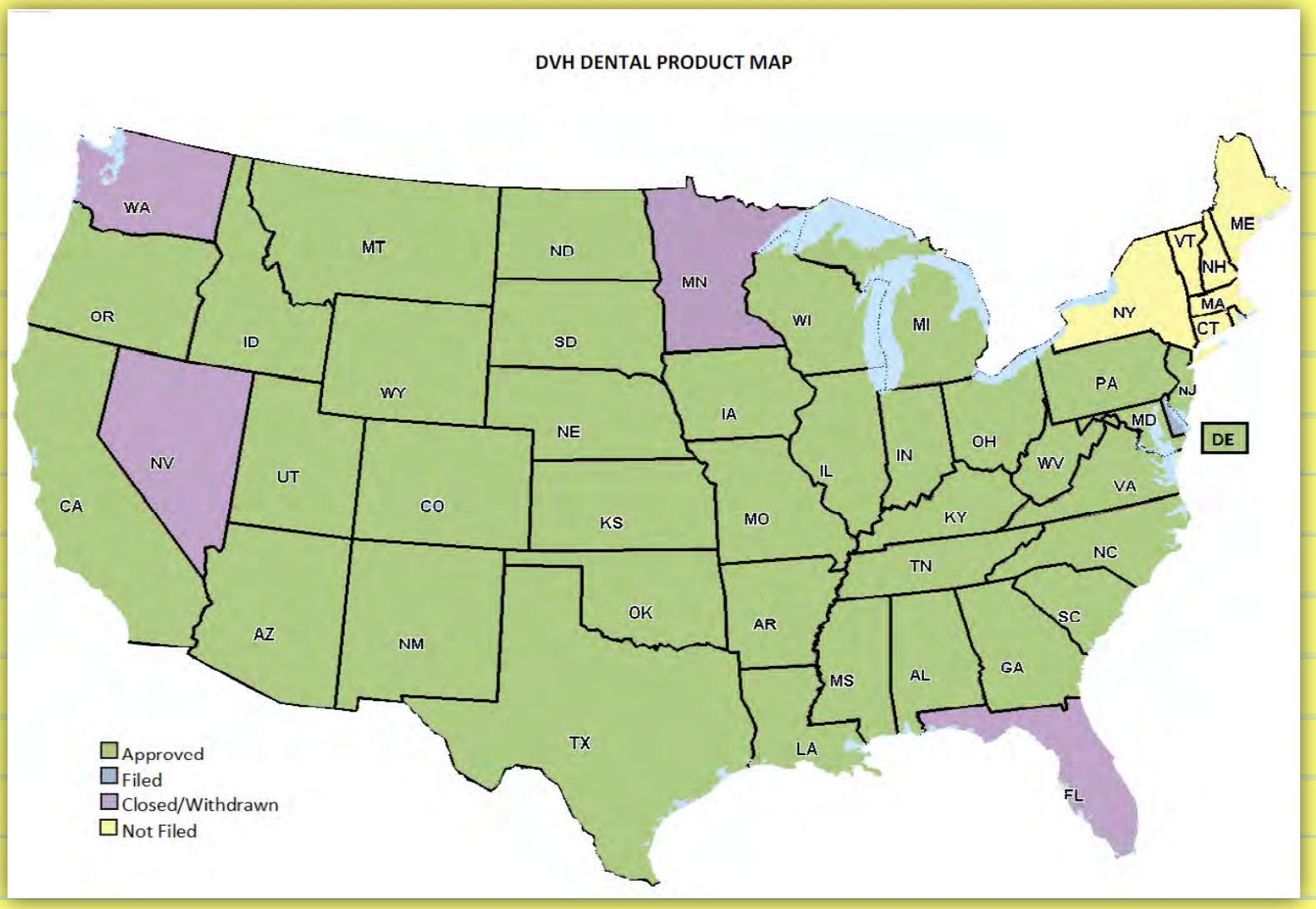
A plan with choices for you and your family

This is a Limited Benefit Insurance Policy for Dental, Vision and Hearing Expenses.

Not available in all states.

lgarza@manhattanlife.com

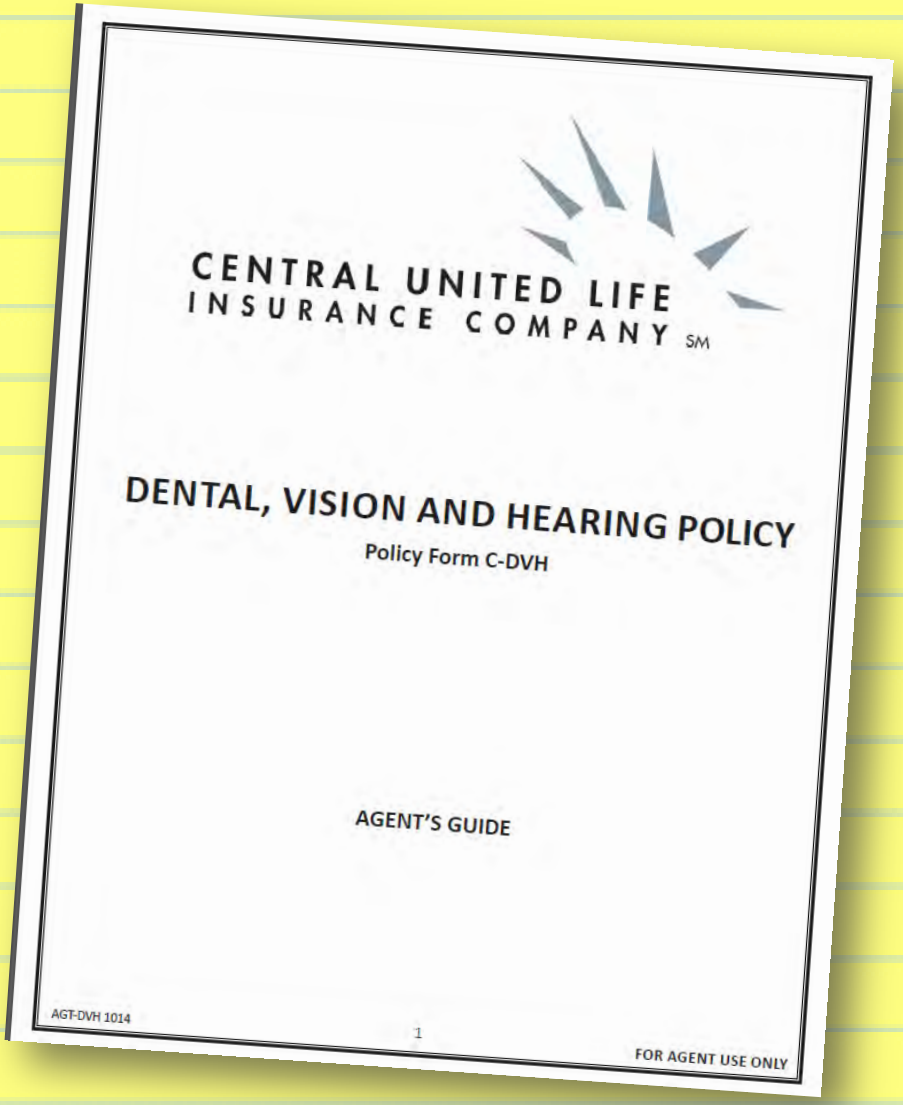
State Availability



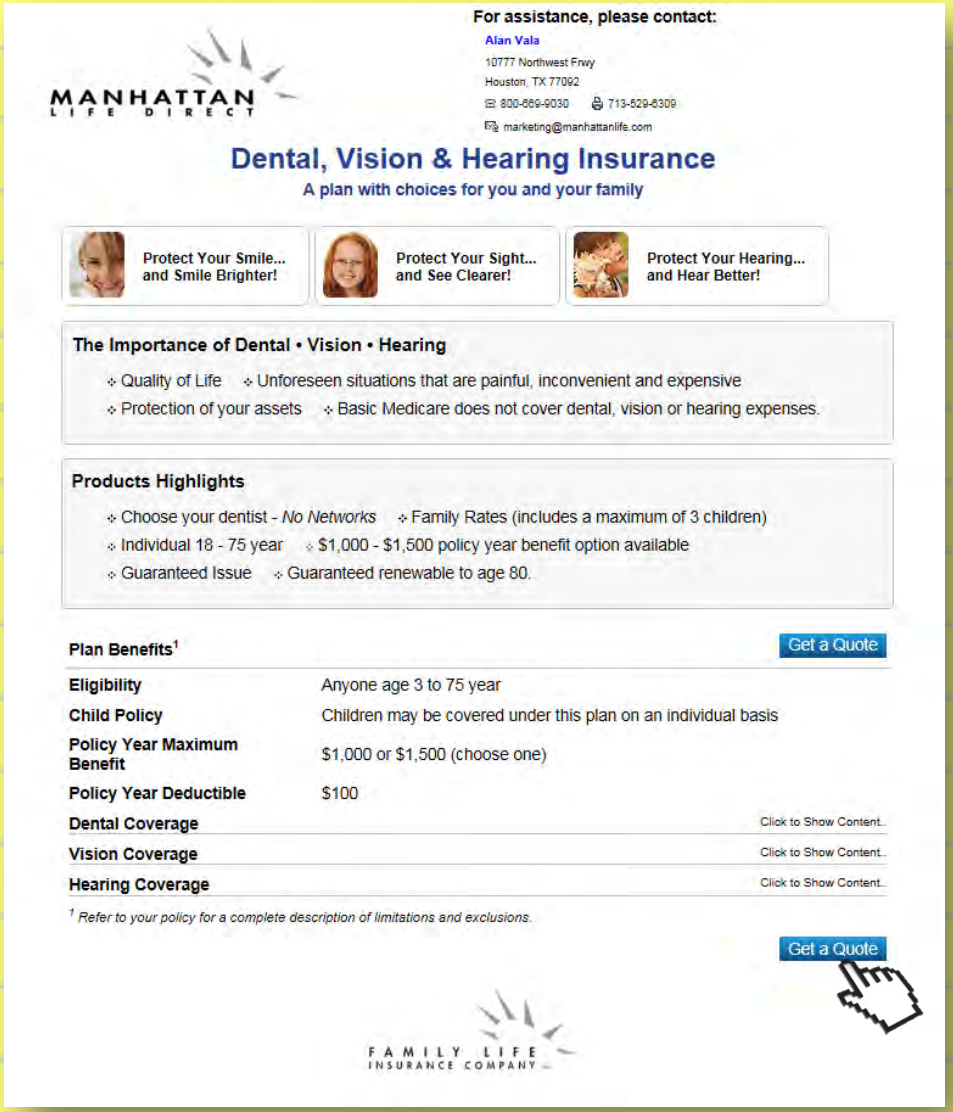
Agent's Guide

Important

Review our Agent's Guide for detailed underwriting guidelines.



Manhattan Direct



MANHATTAN LIFE DIRECT

For assistance, please contact:

Alan Vala
10777 Northwest Fwy
Houston, TX 77092
800-669-9030 713-529-6309
marketing@manhattanlife.com

Dental, Vision & Hearing Insurance

A plan with choices for you and your family

Protect Your Smile... and Smile Brighter! | **Protect Your Sight... and See Clearer!** | **Protect Your Hearing... and Hear Better!**

The Importance of Dental • Vision • Hearing

- Quality of Life
- Unforeseen situations that are painful, inconvenient and expensive
- Protection of your assets
- Basic Medicare does not cover dental, vision or hearing expenses.

Products Highlights

- Choose your dentist - *No Networks*
- Family Rates (includes a maximum of 3 children)
- Individual 18 - 75 year
- $1,000 - $1,500 policy year benefit option available
- Guaranteed Issue
- Guaranteed renewable to age 80.

Plan Benefits[1] Get a Quote

Eligibility	Anyone age 3 to 75 year
Child Policy	Children may be covered under this plan on an individual basis
Policy Year Maximum Benefit	$1,000 or $1,500 (choose one)
Policy Year Deductible	$100
Dental Coverage	Click to Show Content..
Vision Coverage	Click to Show Content..
Hearing Coverage	Click to Show Content..

[1] *Refer to your policy for a complete description of limitations and exclusions.*

Get a Quote

FAMILY LIFE INSURANCE COMPANY

Our convenient online application is available for you or your client to complete from the comfort of your home.

MANHATTAN LIFE DIRECT

For assistance, please contact:

Alan Vala

10777 Northwest Frwy

Houston, TX 77092

☎ 800-669-9030 🖷 713-529-6309

✉ marketing@manhattanlife.com

Dental, Vision & Hearing Insurance

A plan with choices for you and your family

As easy as 1... 2... 3

1. *Tell us about you* | **2.** *Get a Quote* | **3.** *Apply Online*

Tell us about you

Applicant: * Please Select **Birth Date:** * MM/DD/YYYY **Year** **Gender:** * Select **Tobacco User?:** * Select

State: * Select **Payment Mode:** * Monthly **Effective Date:** * 06/15/2015

Get a Quote

FAMILY LIFE INSURANCE COMPANY℠

MANHATTAN LIFE DIRECT

For assistance, please contact:

Alan Vala

10777 Northwest Frwy

Houston, TX 77092

800-669-9030 713-529-6309

marketing@manhattanlife.com

Dental, Vision & Hearing Insurance

A plan with choices for you and your family

As easy as 1... 2... 3

1. *Tell us about you* ***2.*** *Get a Quote* ***3.*** *Apply Online*

Tell us about you

Applicant: * Self | Birth Date: * 01/01/1980 35 Year | Gender: * Male | Tobacco User?: * No

State: * TX - Texas | Payment Mode: * Monthly | Effective Date: * 06/15/2015

Plan Name:	Plan Premium:
○ $1,000 Benefit	$25.00
◉ $1,500 Benefit	$33.00

Applicant's Information

Name: * Last Name * | SSN / ITIN : * | Gender: * Male | Weight: * lb

Height: * Select 0 | Marital Status: * Select

Email: * | Home Phone: * | Work Phone:

Employer's Name: * | Occupation/ Duties: *

Hired Date: *

Residential Address

Address 1: * | Address 2: | City: *

State: * TX - Texas | Zip: *

Mailing Address ☐ Same as Residential Address

Address 1: * | Address 2: | City: *

State: * Select | Zip: *

Premium Payer ☐ Other than Applicant

Name: First Name Last Name

Address: City: State: Select Zip:

Phone: **Email:**

Billing

Payment By: * Select

General Questions

a> Do you, or any proposed insured persons, have any dental, vision, or hearing insurance currently in force? ○ Yes ○ No *

b> Is the insurance applied for intended to replace any existing insurance with this or any other company? ○ Yes ○ No *

If Yes, please provide type of contract or policy number and name of company:

c> If replacement is involved, have you received a replacement form (in states required by law)? ○ Yes ○ No *

Mail To: * Select

Name: * Address 1: *

Address 2: City: * State: * Select State Zip: *

Special Request:

Email Consent Authorization

◉ I give my written consent to allow the Company to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(es) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

Primary Email Address: * Secondary Email Address:

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

○ I decline to give consent to the Company to communicate with me by email.

Insured's Authorization

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete, and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and, (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

I, the undersigned applicant, certify that I have read, or had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I have received the Outline of Coverage for the policy (in states required by law).

Agent #: test999 Agent's Name: Alan Vala Agent's Signature:

(Mother's Maiden Name)

Agent Phone#: 800-669-9030

FRAUD WARNING:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of criminal offense under state law. I agree that no insurance shall be in effect until: (a) a policy has been issued; and (b) the first premium is paid while my insurability remains unchanged and then only if I am actually in the state of health represented in this application. I state that the answers set forth above, are full, complete and true to the best of my knowledge and belief. The answers are to be the basis of any insurance issued. I also acknowledge that I have received the Investigative Consumer Reports notification and MIB Notice attached to this application. All statements made by or on behalf of the insured or annuitant shall be deemed to be representations and not warranties.

By entering your Mother's maiden name you are electronically signing the application thereby giving us authorization to obtain information and process the application. Clicking "Submit" acknowledges that you have read and agree to the Consent and Disclosure to Use Online E-Signatures. [Click to print/download]

Mother's maiden name: *

Submit

FAMILY LIFE INSURANCE COMPANY SM

MANHATTAN LIFE DIRECT

For assistance, please contact:

Alan Vala

10777 Northwest Frwy

Houston, TX 77092

☎ 800-669-9030 🖷 713-529-6309

marketing@manhattanlife.com

Your application has been submitted successfully!

Thank you very much!

We may contact you for further information.

If you have any questions or need assistance, please contact our authorized representative noted above.

View the Application

Submit Another Application | View/Choose Another Product | I am Done

FAMILY LIFE INSURANCE COMPANY SM

Our Paper Application

❑ New Application
❑ Reinstatement
❑ Policy Change

CENTRAL UNITED LIFE INSURANCE COMPANY
10777 Northwest Freeway, Houston, TX 77092
Dental, Vision, and Hearing Insurance Application

WARNING: 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 maybe committing a fraudulent insurance act, which is a crime.

APPLICANT INFORMATION

Name (Last, First, Middle Initial)		Date of Birth	Height	Weight	Gender (M/F)
Address (Street, City, State, ZIP Code)					
Telephone Numbers (Home, Work, and Cell)		Email Address			
Social Security Number	Employer		Hire Date	Type of Business	
Applicant's Current Occupation					
Requested Effective Date (optional):	Mail Policy To: ❑ Insured ❑ Agent				

DEPENDENT(S) INFORMATION

Name (Print Full Name)	Social Security Number	Gender (M/F)	Date of Birth	Height	Weight (Lbs.)

GENERAL QUESTIONS

1. (a) Do you, or any proposed insured persons, have any dental, vision, or hearing insurance currently in force?	❑ Yes ❑ No
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company ? If, "Yes," provide type of contract or policy number, and name of company:	❑ Yes ❑ No
(c) If replacement is involved, have you received a replacement form (in states required by law)?	❑ Yes ❑ No

COVERAGE APPLIED FOR

Dental, Vision, and Hearing	❑ Applicant Only ❑ Family (Family Coverage is up to 5 persons) Policy Year Maximum: ❑ $1,000 ❑ $1,500 Premiums: _____

EMAIL CONSENT AUTHORIZATION

❑ I give my written consent to allow Central United Life Insurance Company (the Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(es) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company in writing of such revocation.

❑ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below.)

Primary email address: _____

Secondary email address: _____

Signature: _____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

Submit Completed Form to: New Business Department, 10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone Number: 1-800-999-2971

C-DVHAP15 (rev. 3.17.15) 1

- Mail
- Fax
- E-mail
- FTP Site
- Must see client
- Live Signature

CLAIM FOR DENTAL EXPENSE BENEFITS

- Submit x-rays with:
  - treatments involving gold restoration, crowns root canals, or bridgework.
    X-RAYS MAY BE REQUESTED FOR OTHER SERVICES

Any person who knowingly and with intent to injure, defraud, or deceive any Insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree

MAIL TO:
CLAIMS DEPARTMENT
P.O. BOX 925309
HOUSTON, TX 77292-2728

PART 1

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE SELF / SPOUSE / CHILD / OTHER	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YEAR	5. IF FULL TIME STUDENT SCHOOL / CITY

6. EMPLOYEE NAME FIRST / MIDDLE / LAST	7. EMPLOYEE SOCIAL SECURITY NO.	8. EMPLOYEE POLICY #	9. GROUP NUMBER IF KNOWN

10. EMPLOYEE MAILING ADDRESS	CITY, STATE	ZIP	11. EMPLOYER (COMPANY) NAME AND ADDRESS	CITY, STATE	ZIP

12. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ NO ☐ YES EMPLOYEE NAME / SOC. SEC. NO.	13. NAME AND ADDRESS OF EMPLOYER IN ITEM 12.

14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ NO ☐ YES If yes, give	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER

15a. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.	15b. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

Part 2

PATIENT'S SIGNATURE (PARENT IF A MINOR) / DATE	EMPLOYEE'S SIGNATURE / DATE

16. DENTIST NAME FIRST / MIDDLE / LAST	17. MAILING ADDRESS	CITY, STATE	ZIP

18. DENTIST SOC. SEC. OR TIN	19. DENTIST LICENSE NO.	20. DENTIST PHONE NO.

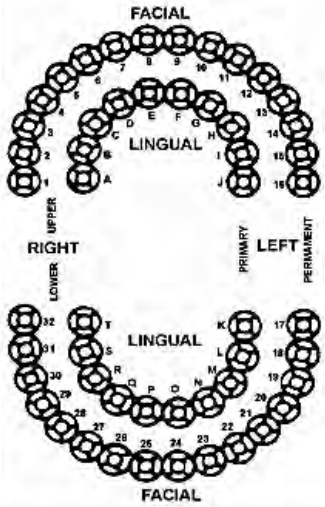
21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT OFFICE / HOSP. / ECF / OTHER	23. RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY?

	NO	YES	
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS IS THIS INITIAL PLACEMENT?			(IF NO. REASON FOR REPLACEMENT) / 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

TO BE COMPLETED BY DENTIST

31. DENTIST – CHECK ONE

☐ PRETREATMENT ESTIMATE
☐ STATEMENT OF ACTUAL SERVICES



32. EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32
USE CHARTING SYSTEM SHOWN

Tooth No. or Ltr.	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis Materials Used, etc.)	Date Service Performed Mo.	Day	Yr.	Procedure Number (see over)	FEE	

FOR HOME OFFICE USE ONLY

☐ SCHEDULE
☐ OTHER

DENTAL UNIT USE

Employee Eligible Date _____
Employee Effective Date _____
Termination Date _____
Verified By _____
Date _____

TOTAL FEE ACTUALLY CHARGED

DEDUCTBLE

PATIENT PAYS

INSURANCE WILL PAY

THESE BENEFITS WILL, SUBJECT TO POLICY PROVISIONS, BE PAYABLE IF THE DESCRIBED PROCEDURES ARE PERFORMED WHILE THE PATIENT IS INSURED WITH FIRST UNUM INSURANCE COMPANY

Part 3 TO BE COMPLETED BY DENTIST

I HERBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE ABOVE NAMED PATIENT ON THE DATES INDICATED

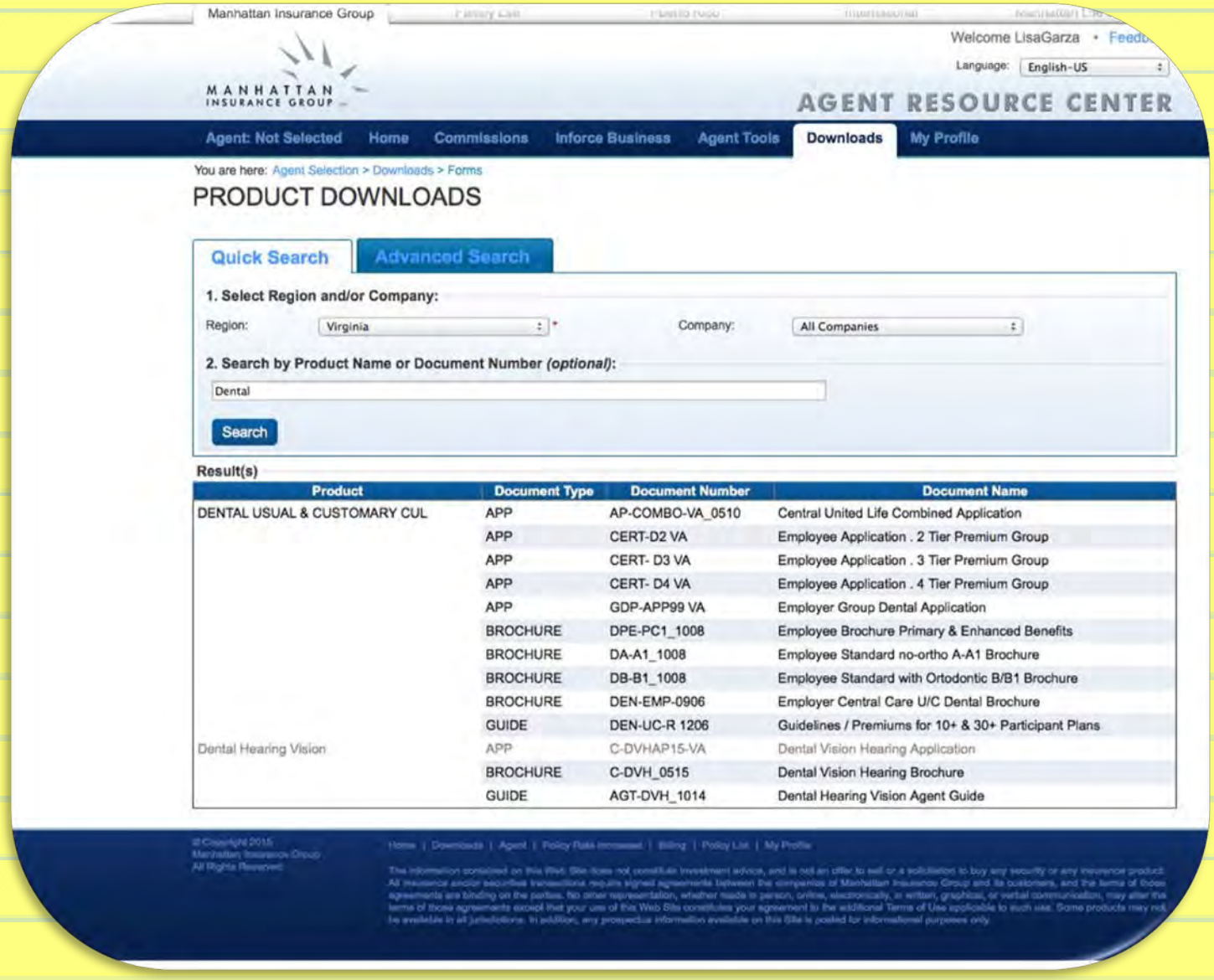
DENTIST SIGNATURE _____ DATE _____

DENT-CLM

www.manhattanlife.com

MANHATTAN INSURANCE GROUP

Visit Our Website



WWW.MANHATTANLIFE.COM

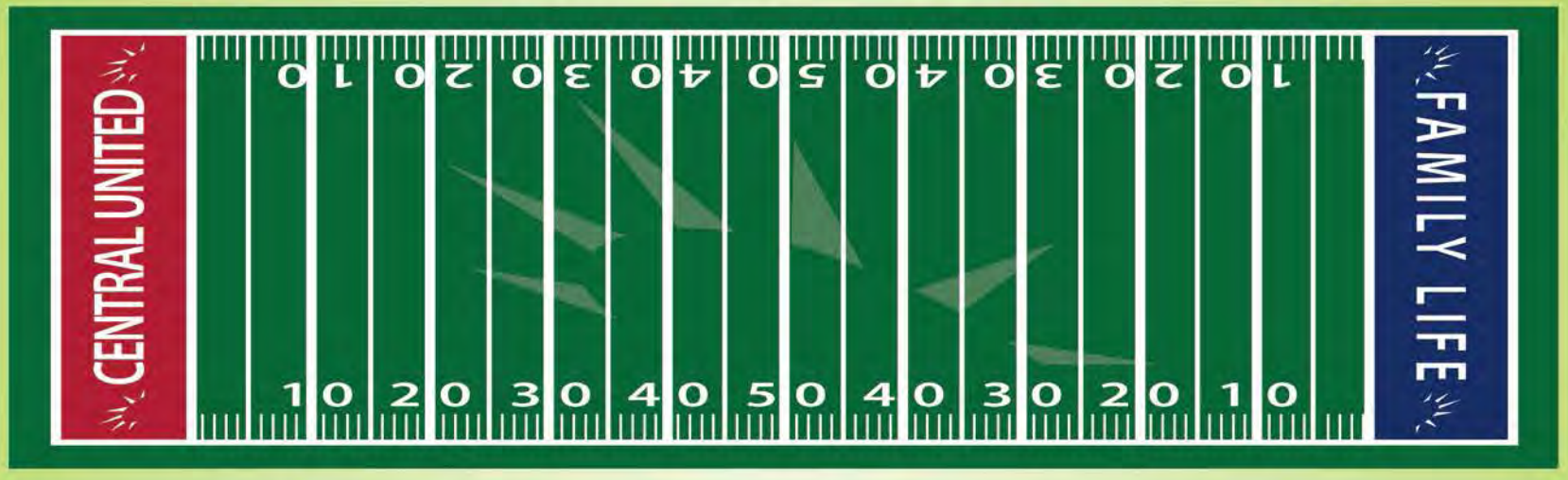
Go Texans!

Go Texans!

Are you ready.... for some Football!

Houston Texans vs Indianapolis Colts
Thursday October 8, 2015

Contest Period June 1 - August 31, 2015



12 Winners Recieve . . .

* Airfare to Houston for Associate and Spouse or Guest
* Two nights hotel at the Sheraton Brookhollow Hotel
* Home Office visit
* Pre-Game party at NRG Stadium
* Houston Texans Tickets

CENTRAL UNITED LIFE INSURANCE COMPANY℠

FAMILY LIFE INSURANCE COMPANY℠

Experience Italy in 2016

Venice

Rome

Imagine Yourself . . .

In Rome

- trying your hand in the "mouth of truth"
- making a wish at the Trevi Fountain
- or walking the paths of gladiators in the Colosseum

In Venice

- sipping coffee at the Piazzo San Marco
- riding a gondola under the Rialto Bridge
- or touring Ca'D'oro a 15th century gothic palace

MANHATTAN INSURANCE GROUP

Chairman's Club 2016

Contest Period May 1, 2015 to April 30, 2016

Chairman's Club 2016

Qualifications

Marketing Director = $500,000 npap*

General Agent = $300,000 npap*

Call Center = $250,000 npap* (with 80% first year persistency)

Personal = $100,000 npap*

New Agent Contract after September 1, 2015 = $75,000 npap*

125% credit for Cancer Care CP4000 sales

150% credit for new Cancer Care CP4000 sales when submitted with a new group and with a minimum of 5 Cancer Care Lives

Please Note: credit for other product sales will be the normal amount.

**Net paid annualized premium*

Chairman's Club Qualifications

MANHATTAN/CENTRAL UNITED/FAMILY LIFE INSURANCE COMPANIES

The following guidelines will be followed to qualify associates and agency managers for the 2016 Chairman's Club Conference:

1. The qualification period will be from May 1, 2015 to April 30, 2016. Only net paid annualized premium produced during the qualification period will count for conference qualification. Qualification numbers are not final until April 30, 2016.
2. The Company will confirm qualification for the conference by a personal invitation to the associate.
3. Only active contracted and producing associates in good standing at the time of the conference will be eligible to attend the conference.
4. Business written on an associates own life or on immediate family members will not be eligible for qualification for the conference. Immediate family members include spouse,mother, father, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, and children.
5. Business written on another associate in the agency will not be eligible for qualification for the conference.
6. Production credit is not transferable among associates or agency managers.
7. Multiple associate qualifications are not allowed.
8. A minimum portfolio persistency of 85% is required.
9. If an associate qualifies for the conference on a personal, agency or Marketing Director basis, the associate will only be awarded one qualification.
10. Cash will not be paid in lieu of attending the conference.
11. The qualifying associate will be allowed to bring their spouse or guest. A guest can not be a contracted associate with the Company. Children are welcome at the expense of the associate.
12. The Company reserves the right to modify or cancel the event if deemed necessary.
13. In accordance with IRS rules and regulations, associates attending our Chairman's Club Conference will receive 1099 earnings for the fair market value of the trip. Please consult your tax advisor if you have any questions concerning your income reporting requirements.
14. Any exceptions to the above guidelines or special requests must be approved by the Director of Marketing of the Company.

CC2015 Dom

President's Club 2016 ASPEN

Join us at the prestigious St. Regis Aspen Resort

Contest Period
May 1, 2015 - April 30, 2016

Qualifications

Marketing Director:	**$400,000 with 3 qualifiers in attendance**
Agency:	**$250,000 NPAP**
Personal:	**$50,000 NPAP**

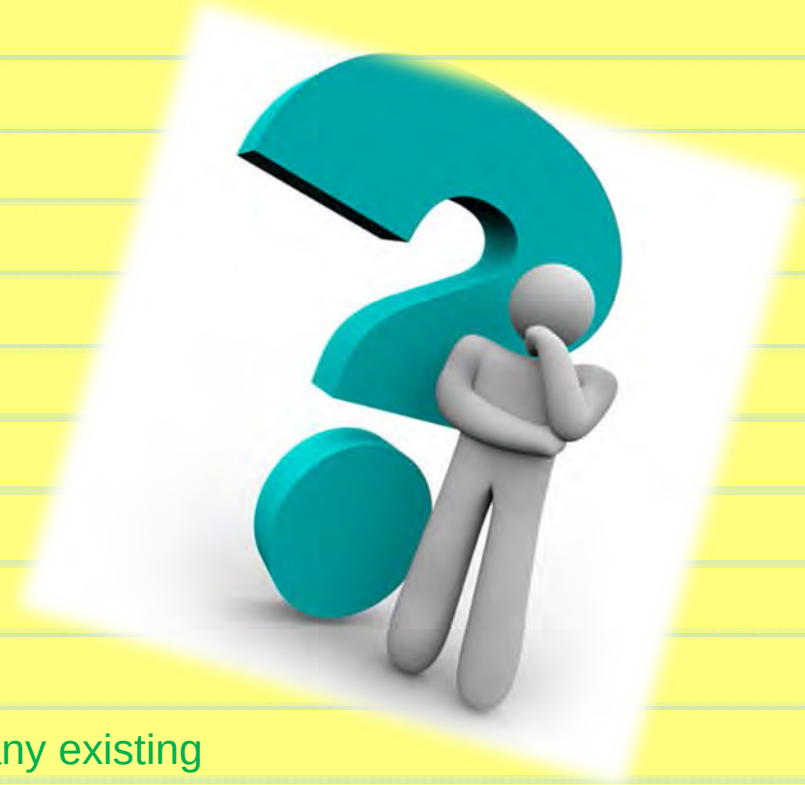
Guidelines

MANHATTAN/CENTRAL UNITED/FAMILY LIFE INSURANCE COMPANIES

The following guidelines will be followed to qualify associates and agency managers for the 2016 President's Club Conference:

1. The qualification period will be from May 1, 2015 to April 30, 2016. Only net paid annualized premium produced during the qualification period will count for conference qualification. Qualification numbers are not final until April 30, 2016.
2. 50% premium credit for First Choice, Group Dental, Vision, Employer Paid Group Life, and Employer Paid Group Accident.
3. The Company will confirm qualification for the conference by a personal invitation to the associate.
4. Only active contracted and producing associates in good standing at the time of the conference will be eligible to attend the conference.
5. Business written on an associates own life or on immediate family members will not be eligible for qualification for the conference. Immediate family members include spouse,mother, father, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, and children.
6. Business written on another associate or their family in the agency will not be eligible for qualification for the conference.
7. Production credit is not transferable among associates or agency managers.
8. Multiple associate qualifications are not allowed.
9. A minimum portfolio persistency of 85% is required.
10. If an associate qualifies for the conference on a personal, agency or Marketing Director basis, the associate will only be awarded one qualification.
11. Cash will not be paid in lieu of attending the conference.
12. The qualifying associate will be allowed to bring their spouse or guest. A guest can not be a contracted associate with the Company. Children are welcome at the expense of the associate.
13. The Company reserves the right to modify or cancel the event if deemed necessary.
14. In accordance with IRS rules and regulations, associates attending our Chairman's Club Conference will receive 1099 earnings for the fair market value of the trip. Please consult your tax advisor if you have any questions concerning your income reporting requirements.
15. Any exceptions to the above guidelines or special requests must be approved by the Director of Marketing of the Company.

FAQ's



- Group or individual product?

The policy form is an Individual product. This product can be written to Individuals or any individual in a group and added to group bill.

- Guarantee Issue?

Yes, medical questions are not asked.

- Group Eligibility

You can add one dental policy to any existing CUL group bill. For a new group you need 3 dental applications.

- Effective Dates

The "Effective Date" of a policy will be the policy date stated on the policy schedule page. It is not the date the application signed. Coverage begins on effective date.

- Portable?

Yes

- Waiting Periods:
  - Dental Coverage 12 months waiting period for: Major services, including bridges, crowns, full dentures or partials, full mouth extractions and root canals.
  - Vision Coverage 6 months waiting period for eye glasses and contact lenses.
  - Hearing coverage 12 months waiting period for new hearing aids and existing hearing aids repairs.

Dental, Vision and Hearing Insurance

A plan with choices for you and your family

This is a Limited Benefit Insurance Policy for Dental, Vision and Hearing Expenses.

CENTRAL UNITED LIFE INSURANCE COMPANY℠

C-DVH 1214

Not available in all states.