Lakeshore Insurance Services

For Individuals

Dental Insurance Application

1. Complete all areas in the application form below. Please be sure to read all information fully and sign where indicated on the back.
2. Indicate the type of coverage you want (Individual, Individual & Spouse, etc.) and how you want to pay (automatic checking account deduction or credit card charge).
3. Return this entire sheet in the envelope provided. Send no money. Once approved, your policy and ID card will be mailed or emailed to you.

National Guardian Life Insurance Company

Underwritten by: National Guardian Life Insurance Company • Two East Gilman St. • PO Box 1191 • Madison, WI 53701
Administered by: Cypress Dental Administrators • 7510 Shoreline Drive, Suite A-1 • Stockton, CA 95219 • 1-800-350-3989

To Be Completed by Applicant:

Applicant's Name: _____
Last First Middle Initial

Applicant's Address: _____
Street or Post Office Box Apartment Number

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/_____ (MM DD YYYY) ❑ Male ❑ Female Last 4 Digits of Applicant's Social Security Number: ___ ___ ___ ___

Name of Spouse (if to be insured): _____
Last First Middle Initial

Spouse Date of Birth: ____/____/_____ (MM DD YYYY) ❑ Male ❑ Female Home Telephone Number: (_____)_____

Email Address: _____ Is it OK to email your policy? ❑ Yes ❑ No

Check Coverage Desired: ❑ Individual ❑ Individual & Spouse ❑ One-Parent Family ❑ Two-Parent Family

Indicated Method of Payment (Checking account deduction or credit card payment only):

❑ Deduct premium payments from my checking account automatically. (My voided check is enclosed.)
❑ Charge future payments to: ❑ VISA ❑ MasterCard

Credit Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiration Date (MM/YY): _____/_____

I Want to Pay: ❑ Every Month ❑ Every 3 Months ❑ Every 6 Months ❑ Every 12 Months

To Be Completed for Each Dependent Child (if to be insured):

CHILD'S NAME (Last, First, Middle Initial)	DATE OF BIRTH (MM/DD/YYYY)	GENDER	CHECK IF:
		❑ Male ❑ Female	❑ Handicapped Child ❑ Full-Time Student
		❑ Male ❑ Female	❑ Handicapped Child ❑ Full-Time Student
		❑ Male ❑ Female	❑ Handicapped Child ❑ Full-Time Student
		❑ Male ❑ Female	❑ Handicapped Child ❑ Full-Time Student
		❑ Male ❑ Female	❑ Handicapped Child ❑ Full-Time Student
		❑ Male ❑ Female	❑ Handicapped Child ❑ Full-Time Student

Do You have, or did you have within 30 days of this application, any other dental insurance in force with another company? ❑ Yes ❑ No

Warning: Failure to disclose existing coverage, your intentions to replace such coverage, or the existence of coverage terminated within 30 days of this application may result in the denial of a claim or the rescinding of your coverage under the policy for which you are applying.

Is this insurance intended to replace any other insurance now in force? ❑ Yes ❑ No

Please give the following information for any dental insurance now in force:

COMPANY NAME	BENEFIT	POLICY NUMBER	BEING REPLACED?

APPLICATION CONTINUED ON OTHER SIDE. PLEASE READ, SIGN AND DATE WHERE INDICATED.
For questions call 1-800-350-3989

(Over, please)

Applicant's Statements and Agreements:

1. I understand the effective date of the policy will be the date recorded in the Policy Schedule of Benefits by Us.
2. I understand the policy I am applying for contains different Waiting Periods for certain benefits listed in the Policy Schedule of Benefits. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the effective date of coverage.
3. I understand that dependent children, if any, will be covered until the end of the month following their 19th birthday (24th if full-time student).
4. I acknowledge receipt of, if applicable: ❑ Outline of Coverage.
5. I understand that: (a) National Guardian Life Insurance Company is not bound by any statement made by me, the applicant, or any associate/agent of National Guardian Life Insurance Company unless written herein; (b) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy together with this application, endorsements, benefit agreements and riders, if any, is the entire contract of insurance; (d) No change to the policy will be valid until approved by our president and secretary, and noted in or attached to the policy.

Notice of Information Practices:

To issue an insurance policy, we may need to obtain additional information about You and any other persons proposed for insurance. Some information will come from You and some may come from other sources. That information and any other subsequent information collected by Us may in some circumstances be disclosed to third parties without Your specific consent. You have the right to access and correct the information collected about You except information that relates to a claim or to a civil or criminal proceeding. If You wish to have a more detailed explanation of our information practices, please submit a written request to Us. This notice applies only in Arizona, California, Georgia, Illinios, Maine, Minnesota, Montana, Nevada, North Carolina, Oregon and Virginia.

Authorization to Obtain Information:

National Guardian Life Insurance Company, or its authorized representative, may obtain medical information about me in order to evaluate my application for disability insurance. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical laboratory or other medically-related facility, the Veterans Administration, insurance company or its reinsurers that has any records or knowledge about medical care, treatment, diagnosis or advice rendered to me to give to (Insurance Company), its reinsurer or authorized representative, any such information in the event National Guardian Life Insurance Company finds such information necessary. This Authorization shall be valid for 30 months from the date shown below. A photocopy of this authorization shall be as valid as the original.

PLEASE NOTE: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

I also understand that if I am receiving Medicaid benefits, the purchase of this coverage may not be necessary.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the National Guardian Life Insurance Company Policy. I have read, or had read to me, the completed application, and I realize policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of 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 may subject such person to criminal and civil penalties.

Signed and Dated at _____ on ____/____/____
City and State Date

Applicant's Signature: _____

Agent's Signature: _____ Agent: No.: _____ Date: _____
Licensed Resident Associate/Agent

Underwritten by National Guardian Life Insurance Company.