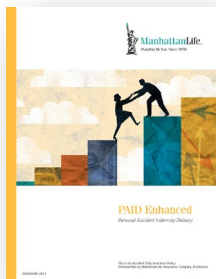




ManhattanLife™

Standing By You. Since 1850.™



Dental, Vision, & Hearing Select

DVH Statistics



- 92% of adults 20 to 64 have had dental problems in their permanent teeth.
- 26% of adults 20 to 64 have untreated decay.
- 62% of adult population in the United States uses prescriptive eyewear, and the number of visually impaired people will likely double by 2030 according to Vision Watch.
- 1 out of 4 children have vision problems.
- 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.



Why DVH Select?

The Importance of Dental | Vision | Hearing

- Help maintain quality of life
- Financial protection in unforeseen situations that are painful, inconvenient, and expensive
- Basic Medicare does not cover dental, vision or hearing expenses

PRODUCTS HIGHLIGHTS

- Individual ages 18 – 99
- Family rates (*include up to 3 children*)
- \$0 or \$100 deductible (*does not apply to Preventive Services*)
- Glasses, Contacts and Hearing Aid benefits
- Guaranteed renewable for life*
- Choose your dentist (*in-network or out-of-network*)
- \$1,000, \$1,500, or \$3,000 policy year maximum benefit
- Orthodontia benefit
- No waiting periods for Dental Services (*except Orthodontia*)
- Guaranteed issue

* Subject to our right to change premiums.

Flexibility to choose . . .



Dental Only



Dental and Vision



Dental and Hearing



Dental, Vision and Hearing

Dental, Vision and Hearing Select from ManhattanLife was designed with you in mind. With the ability to choose specific benefits, you can customize a plan tailored to fit your needs.



26% of adults in the United States have untreated tooth decay.¹

46% of adults aged 30 years or older show signs of gum disease.²

Highlights

Individual Ages 18 - 99

Guaranteed Renewable for Life

Orthodontia

No Waiting Periods on Dental

Guaranteed Issue

FlippingBook Link *(click me)*

Plan Benefits

Plan Benefits		Eligibility: Ages 18 – 99	
		Policy Year Maximum Benefit: \$1,000, \$1,500 or \$3,000	
		Policy Year Deductible: \$0 or \$100 per person (does not apply to Preventive Services)	
		In-Network	Out-of-Network
Dental Coverage	Preventive Services		
	<ul style="list-style-type: none"> Dental Exams; 2 per year Cleanings; 2 per year 	<ul style="list-style-type: none"> Bitewing X-Rays; 2 per year Fluoride treatment is for age 16 and under; 2 visits per year 	<ul style="list-style-type: none"> 100% of contracted rate 80% of UCR
	Basic Services		
	<ul style="list-style-type: none"> Limited Oral Evaluation Diagnostic Consultation Emergency Palliative Treatment Panoramic X-Ray Periapical X-Ray Periodontal Non-Surgical Service 	<ul style="list-style-type: none"> Basic Restorative Service Filling Basic Oral Surgery Periodontal Service Non-Surgical Extraction 	<ul style="list-style-type: none"> 65% of contracted rate 1st yr. 80% thereafter 65% of UCR 1st yr. 80% thereafter
	Major Services		
	<ul style="list-style-type: none"> Major Restorative Service Inlay/Onlay/Crown Endodontic Service 	<ul style="list-style-type: none"> Periodontal Service Prosthodontic Service Implants ² 	<ul style="list-style-type: none"> 20% of contracted rate 1st yr. 50% thereafter 20% of UCR 1st yr. 50% thereafter
	All Other Medically Necessary Services (services not listed above)	<ul style="list-style-type: none"> 20% of contracted rate 1st yr. 50% thereafter 	<ul style="list-style-type: none"> 20% of UCR 1st yr. 50% thereafter
	Orthodontia ¹		
	<ul style="list-style-type: none"> Straightening of teeth (for all ages) Lifetime max \$1,500 ² 	<ul style="list-style-type: none"> Year 1 - N/A Year 2+ - 50% 	N/A
Vision Rider	Vision Services		
	<ul style="list-style-type: none"> Eye Exam Single Lenses Trifocal Lenses 	<ul style="list-style-type: none"> Refraction Bifocal Lenses Progressive Lenses 	<ul style="list-style-type: none"> 60% of UCR 1st yr. 70% of UCR 2nd yr. 80% of UCR thereafter
	<ul style="list-style-type: none"> Eye Exam Anti-Reflective Lenses Polycarbonate Lenses Contact Lens Fitting Fee 	<ul style="list-style-type: none"> Contact Lenses 	<ul style="list-style-type: none"> 1 per year \$200 maximum per year \$45; 1 per year \$40; 1 per year \$15; 1 per year
Hearing Rider	Hearing Services		
	<ul style="list-style-type: none"> Hearing Exam 	<ul style="list-style-type: none"> Hearing Aid and Necessary Repairs or Supplies ¹ 	<ul style="list-style-type: none"> \$750 maximum (per ear, per year)

¹ 12 Month Waiting Period; ² Lifetime Maximum \$1,500; ³ 6 Month Waiting Period

Waiting Periods

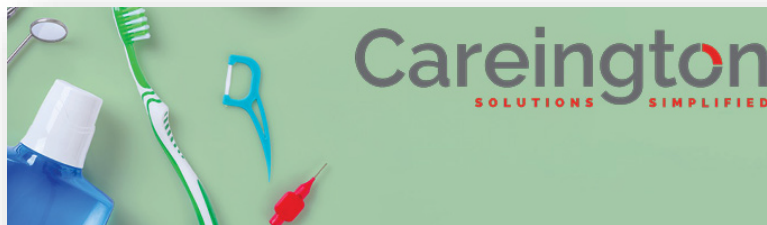
Eye Glass Frames
6Months

Orthodontia
12 Months

Hearing Aid & Supplies
12 Months

Lifetime Max

Orthodontia – \$1,500



We continue our history of “Standing By You” through our partnership with Careington Maximum Care PPO Dental Network. Our partnership provides policyholders access to discounted costs on a wide range of services.

CAREINGTON NETWORK*

Clients can access the Careington Maximum Care PPO Dental Network. Use of network is completely optional.

- Policyholders can benefit from choosing a dental provider from the Careington Dental Network.
- Policyholders can also use the dentist of their choice, even if they are not part of the dental network.
- Network discounts may help extend the policy year maximum with reduced charges.
- Careington can be contacted at (800) 290-0523.

Discounted fees to help your dental benefits go further



Access to quality dentists all around the country



100,000+ Dentists Nationwide



Careington
SOLUTIONS SIMPLIFIED

Claim Examples

Understanding How Your Benefits Work

Dental Coverage	In-Network				
	Peter goes to his Careington Network dentist for a regular check-up. Upon examination, the dentist realizes that Peter needs a filling. Luckily, Peter has a Dental Plan with ManhattanLife. He has met his \$100 annual deductible.				
	Procedure:	Provider Charge	In-Network Cost	ManhattanLife Pays	You Pay
	Dental Exam	\$150	\$35	100% Preventative day one; \$35.00	\$0
	Filling	\$275	\$99	65% Basic day one; (of In-Network Cost = \$64)	\$35 (\$99 - \$64)
	Total	\$425	\$134	\$99	\$35
	Out-of-Network				
Vision Rider	Peter chose not to use the Careington Network and instead goes to an out-of-network dentist for a regular check-up. Upon examination, the dentist realizes that he needs a filling. Peter has a Dental plan with ManhattanLife. He has met his \$100 annual deductible.				
	Procedure:	Provider Charge	Out-of-Network Cost*	ManhattanLife Pays	You Pay
	Dental Exam	\$150	\$96	80% Preventative day one; (of Usual and Customary = \$77)	\$73 (\$150 - \$77)
	Filling	\$225	\$175	65% Basic day one; (of Usual and Customary = \$114)	\$111 (\$225 - \$114)
	Total	\$375	\$271	\$191	\$184
	*subject to the Usual and Customary charges based in zip code 77092				
	Earl goes to the Eye Doctor for an eye exam and gets glasses. He has had a Dental + Vision plan with ManhattanLife for over a year and has met his annual deductible.				
Hearing Rider	Procedure:*	Cost	ManhattanLife Pays		You Pay
	Eye exam	\$60	70% year two \$42		\$18
	Eyeglass Frame	\$250	\$200 maximum; \$200		\$50
	Lenses	\$115	70% year two \$81		\$34
	Total	\$425	\$323		\$102
	*subject to the Usual and Customary charges based in zip code 77092				
	After a 12 month waiting period Brian decides to get his hearing checked, as he's noticed a progressive hearing decline. His ENT specialist recommends Brian get hearing aids to help relieve the hearing loss. Utilizing the hearing portion of the plan, his exam and devices would have been covered as follows:				
	Procedure:*	Cost	ManhattanLife Pays		You Pay
	Hearing Exam	\$90	\$750 maximum per ear, per year: \$90		\$0
	Hearing Aids	\$1,600	\$750 maximum per ear, per year: \$1,500 - \$90 (Hearing Exam) = \$1,410		\$190
	Total	\$1,690	\$1,500		\$190
	*subject to the Usual and Customary charges based in zip code 77092				
	*For illustrative purposes only. Claims examples are subject to geographic region, out of network provider and usual & customary charges.				

While not required, utilizing providers within the Careington Network can provide substantial savings.

Filing a Claim

Click Us

DVH
Claim
Form

Vision
Claim
Form

Proof
of
Loss

The [Easy Upload mobile app](#) or the [Easy Form Upload](#) tool found on the Client Services site can be used to securely send documents to us regarding a specific Life & Health policy or Annuity contract, even if you aren't a registered contract/policy holder. Simply click on the Start Uploading button. You will need to know the contract/policy number and the owner's zip code to use this feature.

cservice@ManhattanLife.com

800-669-9030

Application

1

Take Me to
Generic
Application

☐ New Application
☐ Reinstatement
☐ Benefit Change

ManhattanLife Assurance Company of America
10777 Northwest Freeway, Houston, TX 77092
Dental Insurance Application

PROPOSED INSURED'S INFORMATION

Proposed Insured's Name (First, Middle, Last)		Date of Birth (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)			
Telephone Numbers (Home, Work, and Cell)		Email Address	
Social Security Number	Requested Effective Date	Mail Policy to: <input type="checkbox"/> Agent <input type="checkbox"/> Policyowner	

OWNER'S INFORMATION FOR "CHILD(REN) Only" Coverage

Name (First, Middle, Last)	Relationship to the Child(ren)
Address (Street, City, State, ZIP Code)	
Telephone Numbers (Home, Work, and Cell)	Email Address

OTHER PROPOSED INSURED(S)

Name (First, Middle, Last)	Relationship to Proposed Insured	Date of Birth (MM/DD/YYYY)	Gender (M/F)	Social Security No.

GENERAL QUESTIONS

1. Do you, or any proposed insured(s), have any similar insurance coverage, for which you are applying for, currently in force? ☐ Yes ☐ No If "Yes," provide type of contract, policy number, and the name of company:

2. Is the policy being applied for intended to replace any other insurance? ☐ Yes ☐ No If "Yes," provide type of contract, policy number, and the name of company:

COVERAGE APPLIED FOR

Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Individual/Spouse <input type="checkbox"/> Family Policy Year Deductible: <input type="checkbox"/> \$0 <input type="checkbox"/> \$500 Policy Year Maximum: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000	Riders(s): Hearing Expense <input type="checkbox"/> Yes <input type="checkbox"/> No Vision Expense <input type="checkbox"/> Yes <input type="checkbox"/> No Contact Lenses/Frames: <input type="checkbox"/> \$200	Premium: \$ _____ Base Policy \$ _____ Hearing Rider \$ _____ Vision Rider \$ _____ Total
---	--	--

EMAIL CONSENT AUTHORIZATION

☐ I give my written consent to allow ManhattanLife Assurance Company of America (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
AK7034AP (05/21) Toll Free Telephone Number: (800) 999-2971

ManhattanLife[™]
Standing By You. Since 1850.

Please DO NOT Forget

- Application Type
- Coverage Type
- Deductible
- Policy Year Maximum

Application

2

Take Me to
Generic
Application

INSURED'S AUTHORIZATION AND SIGNATURE

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 ManhattanLife Assurance Company of America (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).

CAUTION: If your answers on this application are incorrect and untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind the policy.

THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE ADMINISTRATIVE OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____ this _____ Day of _____ 20 _____
City, State

X _____ X _____
Signature of Primary Insured Payor/Owner
(Parent if person to be insured is less than 15 years old) (if other than Proposed Insured)

AGENT'S STATEMENT AND CERTIFICATION

All information recorded by me on this application is true and accurate to the best of my knowledge.

Agent No. _____ Soliciting Agent Signature _____ Date _____
Printed Agent Name _____ Agent Phone No. _____ Agent's License No. _____

Please DO NOT Forget

- Application Type
- Coverage Type
- Deductible
- Policy Year Maximum

Application

3

Take Me to
Generic
Application

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Signed at _____ this _____ Day of _____ 20____
City, State

X _____ X _____
Signature of Primary Insured Payor/Owner
(Parent if person to be insured is less than 15 years old) (if other than Proposed Insured)

AGENT'S STATEMENT AND CERTIFICATION

All information recorded by me on this application is true and accurate to the best of my knowledge.

Agent No.	Soliciting Agent Signature	Date
Printed Agent Name	Agent Phone No.	Agent's License No.

Please DO NOT Forget

➤ Agent Statement & Certification



ManhattanLife™

Standing By You. Since 1850.™

The End