Physicians Mutual Insurance Company®

Physicians Mutual®
Insurance for all of us.®

Arizona

Dental Application Booklet

Insurance Policy:
P150AZ - Dental

For Agent Use Only

Physicians Mutual Insurance Company
Underwriting Services
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

Section 1
Dental Required Forms

☐ M-NB-0232-AA-0719C ..... Application Turn in Process Order of Forms Dental

☐ E150-1-0719 ..... Dental Coverage Enrollment..... Home Office Copy

☐ PM2258-0711..... Dental Receipt ..... Applicant's Copy

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Application Turn in Process Order of Forms
Dental

Agents: If applicable, turn in the appropriated forms in the order listed below.

1. DO INFO
   Sales Force Lead Detail Sheet (If Applicable)
2. Special Handling Information
3. Application for Dental
4. Authorization for Automatic Bank Withdrawal
5. Application Checklist
   Assignment of Commission Form
   Business Owner Waiver
6. Quote
7. Emails

PHYSICIANS MUTUAL INSURANCE COMPANY©
2600 Dodge Street – Omaha, NE 68131

DENTAL COVERAGE ENROLLMENT FORM

NAME (Please Print) First Middle Initial Last	**Age**	**Date of Birth** Month Day Year	**Male**	**Female**
Spouse's Name (complete if you choose the Individual/Spouse or All-Family Plan)				
Child				
Child				
Child				

Address _____
Street Apt. No.

_____
City State ZIP

Phone (____) _____

Email _____

(If additional space is needed use the Application Addendum AM5-1296)

Choose the Plan You Want (Check One)

☐ Individual – Plan 4 ☐ Individual/Spouse – Plan 3 ☐ One-Parent – Plan 2 ☐ All-Family – Plan 1

Choose Your Level of Benefits (Check One)	**Optional Vision Rider?**
☐ Schedule A ☐ Schedule D ☐ Schedule E	☐ Yes

Choose Your Method of Payment (Check One)	**Choose Your Mode of Payment** (Check One)
☐ Automatic Bank Withdrawal (Monthly Only) ☐ Direct Bill	☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual

I enclose my first month's premium and enroll for coverage under individual insurance Policy P150. I understand no coverage is in force until the Company issues a Policy.

Signature of Applicant _____

Date _____ Dated at _____
City State

I certify that I have truly and accurately recorded in this enrollment form all information supplied by the Applicant and personally witnessed (his-her) signature.

_____ _____
Signature of Licensed Resident Agent(s) Signature of Licensed Resident Agent(s)

_____ _____
Signature of Licensed Resident Agent(s) Signature of Licensed Resident Agent(s)

Please make check or money order payable to Physicians Mutual Insurance Company

E150-1 (Rev. 0719)

REQUESTED EFFECTIVE DATE _____

POLICYOWNER'S PROXY (for Physicians Mutual Insurance Company)

I hereby appoint the Board of Directors of Physicians Mutual Insurance Company, or a majority of such of them as actually are present, as my proxy with full power and authority to vote and otherwise act for me in my behalf at all annual and special meetings of the policyholders at which I am not present, and I also direct that this proxy shall not expire but shall continue in force until withdrawn by me by written notice mailed to the Company.

Sign Here **X** _____ Date _____

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Dental Receipt

(This does not create interim insurance)

Received from _____ on ____/____/____
Month Day Year

the sum of $_____ (☐ cash ☐ check) for an application for dental insurance offered by Physicians Mutual Insurance Company. It is understood and agreed that no insurance shall be effective until the coverage is issued, and the full first premium has been paid. If this coverage is issued to replace an existing Physicians Mutual Insurance Company policy, this coverage will become effective when your existing coverage terminates. If the application is declined, the Company agrees to refund the above amount to the applicant**. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PHYSICIANS MUTUAL INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

X _____ _____
Agent's Signature Date

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Section 2
Dental Required (If Applicable) Forms

☐ PM2448-1-0817 ..... Authorization for Automatic Bank Withdrawal ..... Home Office Copy

☐ PM1669-0306 ..... Important Notice to Persons on Medicare This Is Not Medicare Supplement Insurance (Given to Applicant's 65 and Older) ..... Applicant's Copy

☐ PM1902A-1010 ..... Business Owner Waiver ..... Home Office Copy

Physicians Mutual Insurance Company
Physicians Life Insurance Company
Underwriting Services
2600 Dodge Street
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Authorization for Automatic Bank Withdrawal

Instructions

1. Select your withdrawal date.
   - If a withdrawal date is not selected, the premium will be withdrawn on or around the scheduled renewal date.
2. Sign and date the Authorization below.
3. Attach a voided check or savings deposit slip to this form; if none available, complete bank information below.

Automatic Bank Withdrawal Date

Requested date of withdrawal _____

Date of the month 1st – 28th

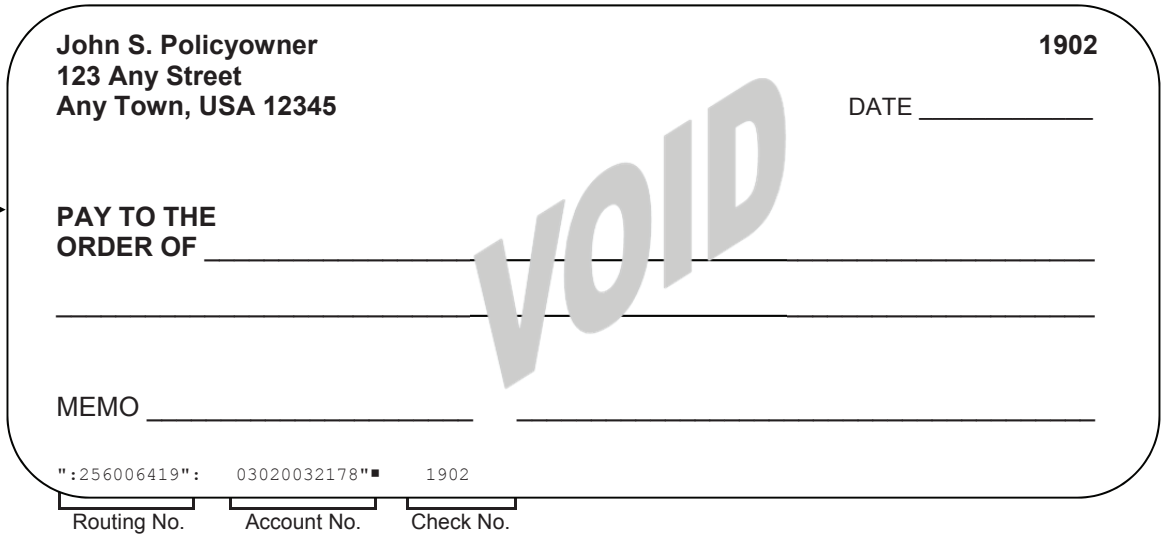
Authorization to Withdraw Funds by Physicians Mutual Insurance Company and/or Physicians Life Insurance Company

I authorize the Company to initiate electronic debit entries to my account. I agree the Company's rights regarding each withdrawal will be the same as if I personally withdrew the funds. The withdrawals made by this method may be stopped by me with thirty (30) days written notice and is to remain in effect until you receive notice from me to revoke it. I understand this authorization can be discontinued immediately for any reason by the Company and will be discontinued if my account is closed or if there are insufficient funds on the scheduled date of the withdrawal

X _____ _____

Bank Account Owner's Signature | Date

Attach a voided check or savings deposit slip here.



Bank Account Information (Only complete if you do not have a voided check or savings deposit slip)

Bank Name: _____ ☐ Checking ☐ Savings

City: _____ State: _____

Routing No.: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account No.: _____

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

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Business Owner Waiver

As the owner of _____, I understand this individual health insurance policy(s) is not and will not be considered a group health plan according to the Employee Retirement Income Security Act (ERISA). Therefore, the premium being paid by the business account will not be used as a business expense. I understand I should contact my tax advisor about the deductions of health insurance premiums.

X _____ _____

Business Owner's Signature | Date