

**Billing Method:**

Monthly Bank Draft (EFT)

Annual Direct Bill

Visa/MasterCard

For Credit Card Payment, please complete the following: I authorize BNL to bill my VISA/MC account for the initial amount due and subsequent regular payments.

Visa  MasterCard

List 16-digit Account # \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature X \_\_\_\_\_

Date \_\_\_\_\_

**Premium Calculations:** *(Send Initial Amount Due with application when selecting monthly bank draft or annual direct bill.)*

Enter Premium (1 month or annual) ..... \$ \_\_\_\_\_

Collection Fee (per billing cycle) ..... + \$ 3.00

One Time Application Fee ..... + \$ 25.00

**Initial Amount Due** ..... = \$ \_\_\_\_\_

Regular Payment (Premium + Collection Fee) ..... \$ \_\_\_\_\_

*Make check payable to: Brokers National Life*

**REQUEST FOR AUTOMATIC MONTHLY BANK DRAFT (EFT)**  
**(Attach a void check)**

If Bank Draft is chosen, your monthly BNL premium will be automatically withdrawn from your checking account. Please complete the Authorization Form below and attach a void check from the account to be drafted:

To \_\_\_\_\_  
*(Print full name of bank or branch where account is maintained.)*

Street Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

I request that you pay and charge my account, debits drawn on my account by BNL to its own order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advance written notice to me and to BNL. You are to treat such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer X \_\_\_\_\_

**AGREEMENT**

To the best of my knowledge and belief, the statements and answers shown in this application form (front and back) are true and complete. I understand the following: (a) if any information stated in this application is incorrect and is material to the risk or hazard assumed by the company, coverage may be avoided; (b) if the application is declined and coverage is not issued, Brokers National Life Assurance Company's only obligation will be to return any premium paid; and (c) the policy effective date will be the first day of the month following receipt of the application. In no event will the policy effective date be the same as the date of receipt.

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. (Except in Colorado, Georgia, Kentucky, Louisiana, Nebraska, Oregon, Pennsylvania, Tennessee & Washington) In Colorado, it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. In Georgia, Nebraska & Oregon, 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 may be guilty of insurance fraud. In Kentucky, 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 commits a fraudulent insurance act, which is a crime. In Louisiana, any person who knowingly presents 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. In Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. In Tennessee, it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. In Washington, 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 a criminal offense under state law.

Dated at (city) \_\_\_\_\_, (state) \_\_\_\_\_

Applicant Signature X \_\_\_\_\_ Date \_\_\_\_\_

Agent's Name (please print) \_\_\_\_\_ Agent's License ID No. \_\_\_\_\_

Licensed Agent Signature X \_\_\_\_\_ BNL Agent No. \_\_\_\_\_ Date \_\_\_\_\_



**BROKERS NATIONAL LIFE ASSURANCE COMPANY**

Domiciled in the State of Arkansas

Administrative Office: 2100 West William Cannon, Suite L, Austin, Texas 78745

Phone: 512-383-0220

**Application for Individual Dental Plan**

Applicant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M / F

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ E-mail \_\_\_\_\_ Phone # \_\_\_\_\_

**Complete the following to insure your spouse and/or children**

Spouse's Name \_\_\_\_\_ Sex M / F Date of Birth (DOB) \_\_\_\_\_

Child's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Sex M / F DOB \_\_\_\_\_

Child's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Sex M / F DOB \_\_\_\_\_

Child's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Sex M / F DOB \_\_\_\_\_

Child's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Sex M / F DOB \_\_\_\_\_

Child's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Sex M / F DOB \_\_\_\_\_

Will this replace existing coverage?  No  Yes If yes, when will existing coverage terminate? \_\_\_\_\_

Does the agent have knowledge this insurance will replace any other insurance?  No  Yes

Effective Date: First of the month following receipt of complete application and Initial Amount Due.

(Do not assume coverage is in force until you receive written confirmation.)

**Plan Selection**

**Choose One:**  Plan A  Plan B

**Choose One:**  Individual Only  Indiv. & One Dep.  Indiv. & Family

**For Home Office Use Only**

Effective Date \_\_\_\_\_  
State ID# \_\_\_\_\_