

**BROKERS NATIONAL LIFE ASSURANCE COMPANY****GROUP DENTAL INSURANCE ENROLLMENT CARD**

NAME OF EMPLOYER						GROUP # _____													
EMPLOYEE NAME		LAST		FIRST		MIDDLE		<input type="checkbox"/> FEMALE		<input type="checkbox"/> MALE									
HOME ADDRESS			STREET			CITY			STATE			ZIP CODE							
HOME TEL. NO. ()				DATE OF BIRTH / /				SOCIAL SECURITY NUMBER				EMPLOYMENT DATE							
MARITAL STATUS				(CHECK ONE):								WORK 30 HOURS PER WEEK?							
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				<input type="checkbox"/> EMPLOYEE ONLY				<input type="checkbox"/> EMPLOYEE AND ONE DEPENDENT				<input type="checkbox"/> EMPLOYEE AND FAMILY				<input type="checkbox"/> YES <input type="checkbox"/> NO			
LIST NAME, SEX AND DATE OF BIRTH OF EACH DEPENDENT YOU WISH TO INSURE STUDENT VERIFICATION MUST ACCOMPANY DEPENDENTS OVER 19.																			
NAME			REL.	SEX	DATE OF BIRTH			NAME			REL.	SEX	DATE OF BIRTH						
DOES YOUR SPOUSE HAVE OTHER COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS THE AMOUNT TO COVER MY SHARE OF THE CONTRIBUTION FOR COVERAGE INDICATED ABOVE. <small>*PROVISIONS ON THE REVERSE SIDE ACCEPTED</small>				<input type="checkbox"/> EMPLOYER PAID				<input type="checkbox"/> EMPLOYEE PAID							
SIGNATURE OF EMPLOYEE				DATE				REQUESTED EFFECTIVE DATE				(CHECK ONE):							
												<input type="checkbox"/> PLAN A <input type="checkbox"/> PLAN B <input type="checkbox"/> BASIC							
IL-GA-1705(08/91).3				DOMICILED IN THE STATE OF ARKANSAS				ADMINISTRATIVE OFFICE: 2100 WEST WILLIAM CANNON, SUITE L, AUSTIN, TEXAS 78745				PHONE: 512-383-0220							

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I hereby apply to BROKERS NATIONAL LIFE ASSURANCE COMPANY for Group Dental Insurance as presented to me and authorize my employer to make any necessary deduction from my salary to pay the premium when my insurance becomes effective.

I further represent that I am not presently disabled and I am performing all the duties of my occupation at least 30 hours per week.

WAIVER OF COVERAGE

I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR GROUP DENTAL INSURANCE, BUT:

DO NOT WISH THIS COVERAGE.

AM COVERED UNDER SPOUSE'S DENTAL PLAN WITH _____
Name of insurance company

Dated this _____ day of _____, 20_____, _____
Individual's Signature

For Home Office Use Only

Plan _____ State _____ FR# _____ EPSI# _____ WP _____ OE _____ Effective Date _____
1 / 15
Notes:

Writing Agent Name _____ Agent # _____

Splitting Agent Name _____ Agent # _____

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