

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\_\_\_\_, \_\_\_\_\_  
For Home Office Use Only \_\_\_\_\_ Individual's Signature

Plan \_\_\_\_\_ State \_\_\_\_\_ FR# \_\_\_\_\_ EPSI# \_\_\_\_\_ WP \_\_\_\_\_ OE \_\_\_\_\_ Effective Date \_\_\_\_\_ 1 / 15

Notes: \_\_\_\_\_

Writing Agent Name \_\_\_\_\_ Agent # \_\_\_\_\_  
Splitting Agent Name \_\_\_\_\_ Agent # \_\_\_\_\_



**BROKERS NATIONAL LIFE ASSURANCE COMPANY**

**GROUP DENTAL INSURANCE ENROLLMENT CARD**

NAME OF EMPLOYER \_\_\_\_\_  
EMPLOYEE NAME LAST FIRST MIDDLE GROUP # \_\_\_\_\_  
HOME ADDRESS STREET CITY STATE ZIP CODE \_\_\_\_\_  
FEMALE  MALE

HOME TEL. NO. ( ) \_\_\_\_\_ DATE OF BIRTH / / \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ EMPLOYMENT DATE \_\_\_\_\_  
MARITAL STATUS: SINGLE  MARRIED  WIDOWED  DIVORCED  (CHECK ONE): EMPLOYEE ONLY  EMPLOYEE AND ONE DEPENDENT  EMPLOYEE AND FAMILY  WORK 30 HOURS PER WEEK? YES  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? YES  NO  I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS THE AMOUNT TO COVER MY SHARE OF THE CONTRIBUTION FOR COVERAGE INDICATED ABOVE.  
SIGNATURE OF EMPLOYEE \_\_\_\_\_ DATE \_\_\_\_\_ REQUESTED EFFECTIVE DATE \_\_\_\_\_  
(CHECK ONE): EMPLOYER PAID  EMPLOYEE PAID  PLAN A  PLAN B  BASIC