

GROUP DENTAL ENROLLMENT CARD

Please make additional copies of this form if needed.

Employer's Business Name _____

Address _____

City _____

State _____

Zip Code _____

Telephone Number _____

Account Number _____

Employee

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

Do you work at least 30 hours per week at this company? Yes No

Name of present dental insurance carrier: _____

Is your Spouse to be insured for dental coverage? Yes No

Are your Children to be insured for dental coverage? Yes No

Soc. Sec. # _____ - _____ - _____

Male Female Date of Birth: Mo. ____ Day ____ Yr. ____

Single Married Occupation: _____

Date of Full-Time Employment: Mo. ____ Day ____ Yr. ____

Date of Part-Time Employment: Mo. ____ Day ____ Yr. ____

(If No, not eligible) Are you applying for dental coverage? Yes No

Date dental coverage terminates: Mo. ____ Day ____ Yr. ____

Is your Spouse covered elsewhere? Yes No

Are your Children covered elsewhere? Yes No

To waive coverage, complete this section. (Ask your employer if a waiver is allowed.)

I decline the insurance coverage my employer offered for: myself dependents because _____

Name of Insurance Company _____ Employer of dependent _____

If I apply for dental insurance in the future, I realize that a "late entrant" penalty may apply.

I request insurance under my Employer's Group Insurance plan as now or hereafter applicable to me, and authorize my Employer to make deductions from my earnings for my share of the cost, if any, of the benefits to which I may become entitled. I represent that the answers I have given are full, complete and true.

Signature _____ Date Signed _____

To be completed by Trust Administrator

Dental Coverage Effective: _____

Dependent Coverage: Spouse only Children only Spouse & Children None

Employee

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

Do you work at least 30 hours per week at this company? Yes No

Name of present dental insurance carrier: _____

Is your Spouse to be insured for dental coverage? Yes No

Are your Children to be insured for dental coverage? Yes No

Soc. Sec. # _____ - _____ - _____

Male Female Date of Birth: Mo. ____ Day ____ Yr. ____

Single Married Occupation: _____

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Signature _____ Date Signed _____

To be completed by Trust Administrator

Dental Coverage Effective: _____

Dependent Coverage: Spouse only Children only Spouse & Children None

Insured by Ameritas Life Insurance Corp./in New York, First Ameritas Life Insurance Corp. of New York

Rates under this policy (subject to maintenance of participation) are fixed for the first 12 months after acceptance. Actual monthly premiums, however, may be affected at any time by changes in the group's location.

Please make additional copies of this form if needed.

Employer's Business Name _____
 Address _____
 City _____ State _____ Zip Code _____
 Telephone Number _____ Account Number _____

Employee

Last Name _____ First Name _____ Middle Initial _____
 Address _____
 City _____ State _____ Zip Code _____

Soc. Sec. # _____ - _____ - _____
 Male Female Date of Birth: Mo. ____ Day ____ Yr. ____
 Single Married Occupation: _____
 Date of Full-Time Employment: Mo. ____ Day ____ Yr. ____
 Date of Part-Time Employment: Mo. ____ Day ____ Yr. ____
 Do you work at least 30 hours per week at this company? Yes No (If No, not eligible) Are you applying for dental coverage? Yes No
 Name of present dental insurance carrier: _____ Date dental coverage terminates: Mo. ____ Day ____ Yr. ____
 Is your Spouse to be insured for dental coverage? Yes No Is your Spouse covered elsewhere? Yes No
 Are your Children to be insured for dental coverage? Yes No Are your Children covered elsewhere? Yes No

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 City _____ State _____ Zip Code _____

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