Security Life Insurance Company of America — PO BOX 1064, SCHENECTADY, NY 12301

# GROUP DENTAL ENROLLMENT FORM

| Soc. Sec. # | Applicants Name (Last, First, Initial) | / / Mo. Day Yr Birthdate | M ☐ F ☐ Sex | For Company Use Only<br>Effective Date | |
|---|---|---|---|---|---|
| Home Address (City, State, Zip) | Telephone No. | Marital Status<br>☐ Married ☐ Single<br>☐ Widowed ☐ Divorced | | Plan Code | |
| Name of Employer or Organization (if applicable) | | Full Time Hire Date | | Waiver | CPT |
| Address (City, State, Zip) (if applicable) | Telephone No. | | | Group Number | Division Number |

**LIST BELOW ALL ELIGIBLE DEPENDENTS TO BE COVERED**

| Last Name (if different) First Name In | Sex M / F | Mo. Day Yr. |
|---|---|---|
| SPOUSE | | |
| CHILDREN | | |
| CHILDREN | | |

**LIST BELOW ALL ELIGIBLE DEPENDENTS TO BE COVERED**

| Last Name (if different) First Name Initial | Sex M / F | Birthdate Mo. Day Yr. |
|---|---|---|
| CHILDREN | | |
| CHILDREN | | |
| CHILDREN | | |

1. Does Spouse have a dental plan? Y☐s ☐o Insurer Name: ______________________
   if answer is "Yes", are dependents enrolled under spouse's☐plan: ☐ Yes No
2. Do you claim a tax exemption for all eligible dependents listed a☐ve? ☐Yes No
3. Are all dependents listed above over age 18 full time stu☐ents? ☐ Yes No

I apply for coverage for:

☐ Myself only

☐ Myself and eligible dependents

**By my signature below, I hereby apply for the coverage provided under th vision insurance policy, issued to the trusteed group policyholder.**

**Applicants Signature** ______________________ Date: __________

☐ **I have been given the opportunity to apply for group insurance at thi not wish to elect coverage**

Signature ______________________________________

**By my signature below, I hereby authorize payroll deductions from my earnings for any contributions required.**

**Applicants Signature** ______________________ **Date:** __________

**This authorization remains in effect until revoked by me in writing.**

Signature ______________________________________

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is g and may be subject to fines and confinement in prison.**

**GA - 1112 (9/00)**