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** Effective Date
Home Address (City, State, Zip) Telephone No.		**Marital Status** ☐ **Married** ☐ **Single** ☐ **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? Yes ☐ No ☐ 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 above? ☐ Yes ☐ No
3. Are all dependents listed above over age 18 full time students? ☐ 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)