



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 <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				(CHECK ONE): <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE AND ONE DEPENDENT <input type="checkbox"/> EMPLOYEE AND FAMILY		WORK 30 HOURS PER WEEK? <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. *PROVISIONS ON THE REVERSE SIDE ACCEPTED.				<input type="checkbox"/> EMPLOYER PAID <input type="checkbox"/> EMPLOYEE PAID		(CHECK ONE): <input type="checkbox"/> PLAN A <input type="checkbox"/> PLAN B <input type="checkbox"/> BASIC	
SIGNATURE OF EMPLOYEE _____			DATE _____		REQUESTED EFFECTIVE DATE _____				

IL GA-1705(08/91) DOMICILED IN THE STATE OF ARKANSAS • ADMINISTRATIVE OFFICE: 2100 WEST WILLIAM CANNON, SUITE L, AUSTIN, TEXAS 78745 • PHONE: 512-383-0220

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# _____	WP _____	OE _____	Effective Date _____
Notes:					1 / 15

