ALLIED DENTAL DESIGN & VISION PLAN
EMPLOYEE ENROLLMENT FORM

(Please type or print in ink - May be copied or duplicated)

1. Employee Information

FULL NAME OF EMPLOYEE				MARITAL STATUS		ADM. USE ONLY
RESIDENCE ADDRESS						CASE NO.
CITY	STATE	ZIP	TELEPHONE NUMBER (include area code)			EMPLOYEE NO.
SEX	DATE OF BIRTH (MM/DD/YY)	EMAIL				CLASS
DATE BEGAN FULL TIME (mm/dd/yy)		SOCIAL SECURITY				EFFECTIVE DATE
EMPLOYER NAME		AVG. # HOURS WORKED WEEKLY		GROSS MONTHLY EARNINGS $		
EMPLOYER'S LOCATION - STREET ADDRESS		CITY		STATE	ZIP	
OCCUPATION, TITLE, DUTIES			EMPLOYER'S PHONE NUMBER (include Area Code)			

2. Benefit Information

Dependents will be enrolled in the same coverage as the employee.

I am applying for (check one): ❑ Self Only ❑ Self & Spouse ❑ Self & Child(ren) ❑Self, Spouse & Child(ren)

I elect: ❑ Dental ❑ Vision

3. Dependent Information

If enrolling for dependent coverage – please list all dependents below

Names of all Dependents to be Insured	Relationship (spouse, son, daughter)	Gender M/F	Date of Birth	Social Security number	Age	Full time student	ADMIN USE ONLY: LAT	D&R T/O	Ortho D&R	PXT
						Y or N				
1.						Y or N				
2.						Y or N				
3.						Y or N				
4.						Y or N				
5.						Y or N				

I am working the average number of hours shown above on a regular basis for the above-named employer. I hereby authorize my employer to make the necessary payroll deduction.

Signature ______________________________ Date ____________________

PLEASE SIGN IN INK

Please mail completed enrollment form to: Allied National, P. O. Box 29187, Shawnee Mission, KS 66201-9187

FOR WAIVER OF ELIGIBILITY, COMPLETE REVERSE SIDE

(may be photocopied or duplicated)

WAIVER OF GROUP DENTAL COVERAGE

AFTER due consideration, I have chosen (check all that apply):

- ❑ Not to enroll myself in the Group Dental Plan being offered by my employer.
- ❑ Not to enroll my spouse in the Group Dental Plan being offered by my employer.
- ❑ Not to enroll my children in the Group Dental Plan being offered by my employer.
- ❑ Not to enroll myself in the Group Vision Plan being offered by my employer.
- ❑ Not to enroll my spouse in the Group Vision Plan being offered by my employer.
- ❑ Not to enroll my children in the Group Vision Plan being offered by my employer.

Please answer the following:

1. I and/or my dependents are covered under another employer-sponsored dental or vision benefit (if you or your spouse are covered under an employer-sponsored plan, please provide the following information) .... ❑ YES ❑ NO

   Employer Name: ____________________

   Name of current insurance carrier above: ____________________

   Insurance carrier phone number: ____________________ Case or Plan Number: ____________

2. I and/or my dependents are covered under an individual dental or vision plan .... ❑ YES ❑ NO

3. I opt not to apply for coverage for myself and/or my dependents in the Group Dental or Vision Plan due to reasons other than having any existing coverage as listed above. I understand that I have the right to apply for coverage at this time and am voluntarily declining coverage. ...... ❑ YES ❑ NO

I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents. Further, I understand that if I and/or my dependents wish to enroll under this plan in the future, I will not be able to until the next plan open enrollment.

Name of Your Employer: ____________________ Case Number: ____________

Date: ____________ Name of Employee: ____________________
(Please Print or Type)

Signature of Employee: ____________________

Social Security Number: ____________________