



New Enrollment Change

Applicant: Please print or type. Complete all areas, sign and date.

Applicant			Group No. _____	
			Effective Date _____	
Home Address		Date of Birth / /		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	ZIP Code	Home Telephone No. ()	Business Telephone No. ()
Your Employer		Date of Hire (full-time)		Social Security Number - -
Employer Address (street, city, state, ZIP)				

Spouse Information - complete only if spouse is to be covered.

Name of Spouse (First MI Last - only if different)	Is your spouse covered under any other dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Separated	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Dependent Child(ren) - list only those children to be covered.

Name (First MI Last-only if different)	Date of Birth	Relationship	Check if over age limit	Name of accredited school
	/ /		<input type="checkbox"/> Full-time student <input type="checkbox"/> Handicapped child	
	/ /		<input type="checkbox"/> Full-time student <input type="checkbox"/> Handicapped child	
	/ /		<input type="checkbox"/> Full-time student <input type="checkbox"/> Handicapped child	
	/ /		<input type="checkbox"/> Full-time student <input type="checkbox"/> Handicapped child	

Enrollment/Change

<input type="checkbox"/> Select Plan <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze	<input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> Policy Change (check reason for change) <input type="checkbox"/> Married <input type="checkbox"/> Address Change <input type="checkbox"/> Widowed <input type="checkbox"/> Terminated <input type="checkbox"/> Divorced Date _____ <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Other _____ Date _____
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Note: Ask your employer for the details about the benefits available to you, and your cost, if any.

I authorize my employer to deduct from my pay any contribution required of me toward the cost of elected dental coverage.

The undersigned on behalf of himself/herself and his/her dependent children, if any, in this application agree to cooperate in providing Fort Dearborn Life Insurance Company or its appointed representative with information needed to process this application or process eligible benefits.

I further understand that I must be actively at work before coverage will become effective. If I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

THIS POLICY PROVIDES DENTAL BENEFITS ONLY. PLEASE REVIEW YOUR CERTIFICATE CAREFULLY.

Employee Signature _____ Date _____