

EMPLOYEE DENTAL INSURANCE APPLICATION

PLEASE PRINT IN SPACE PROVIDED

EMPLOYER INFORMATION					
EMPLOYER NAME			LOCATION		GROUP NO.
EMPLOYEE					
LAST NAME		FIRST NAME			M.I.
STREET ADDRESS		CITY	STATE	ZIP	
SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ()			BIRTH DATE / /
SEX MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>	
COVERAGE – Check Those That Apply (Note: If declining coverage(s), complete the section REFUSAL/WAIVER only)					
<u>Dental Insurance</u>					
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN REQUESTED EFFECTIVE DATE: _____					
DEPENDENT INFORMATION					
SPOUSE NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _____					
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER: _____					
REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent					
I DECLINE DENTAL COVERAGE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY CHILDREN					
REASON FOR REFUSAL: _____					
ACKNOWLEDGMENT AND AUTHORIZATION					
I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. To the best of my knowledge and belief all answers are true and complete.					
WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.					
DATE		CITY AND STATE			
SIGNATURE OF EMPLOYEE					
_____		_____		_____	
Agents Name (Printed, typed, or stamped)		Agents FL License ID Number		Agents Signature	

