

The American Legion Dental Plan

UNDERWRITTEN BY:

The United States Life Insurance Company
in the City of New York

SPONSORED BY:



QUESTIONS? CALL

1-800-522-1857

MAKE CHECKS PAYABLE TO:

Seabury & Smith

RETURN IN ENCLOSED ENVELOPE TO:

Marsh Affinity Group Services
a service of Seabury & Smith
1440 Renaissance Drive
Park Ridge, IL 60068

Administered by:
Marsh Affinity Group Services

APPLICANT—Please print or type. Complete all areas, sign and date.

NAME (FIRST, MIDDLE, LAST) _____ SEX M F

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____ DAYTIME TELEPHONE NUMBER _____

MEMBERSHIP NUMBER _____ ELIGIBILITY DATE (FOR OFFICE USE ONLY) _____

E-MAIL ADDRESS _____

SPOUSE INFORMATION—Complete only if spouse is to be covered.

NAME OF SPOUSE (FIRST, MIDDLE, LAST NAME ONLY IF DIFFERENT) _____

DATE OF BIRTH _____ SPOUSE'S SOCIAL SECURITY NUMBER _____ SEX M F

DEPENDENT CHILD(REN) INFORMATION—Complete only if dependent child(ren) is (are) to be covered. If you desire coverage for more than two children, please attach a separate sheet including the information below.

NAME OF CHILD (FIRST, MIDDLE INITIAL, LAST NAME ONLY IF DIFFERENT) _____ SEX M F

DATE OF BIRTH _____ CHILD'S SOCIAL SECURITY NUMBER _____

NAME OF CHILD (FIRST, MIDDLE INITIAL, LAST NAME ONLY IF DIFFERENT) _____ SEX M F

DATE OF BIRTH _____ CHILD'S SOCIAL SECURITY NUMBER _____

RATES AND BILLING OPTIONS

Please select the type of coverage you would like. Enclose a check for the rate selected and mail it with this enrollment form to Marsh Affinity Group Services.

- Member Only.....\$80.00 Quarterly (Monthly Rate: \$26.67)
- Member +1\$134.00 Quarterly (Monthly Rate: \$44.67)
- Family\$173.00 Quarterly (Monthly Rate: \$57.67)

Indicate how you wish to be billed:
 Automatic Monthly Check Withdrawal
 Quarterly Direct Bill
 (If you select Automatic Monthly Check Withdrawal, please complete the Automatic Monthly Check Withdrawal request at the bottom.)

PLEASE READ AND SIGN

I hereby enroll in The American Legion Dental Plan. I understand that the insurance applied for shall become effective on the date specified by The United States Life Insurance Company in the City of New York only if this Enrollment Form is accepted and the first premium is paid by the Effective Date. I represent that to the best of my knowledge and belief all statements and answers recorded above are true and complete.

X _____ **X** _____
 MEMBER'S SIGNATURE DATE

AUTOMATIC MONTHLY CHECK WITHDRAWAL REQUEST: By selecting automatic check withdrawal, your monthly premium will automatically be withdrawn from your checking account. Please provide the information requested below. Remember to include your first month's premium and a blank voided check with the enrollment form.

Bank Name: _____

Bank Address: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer _____ Date _____

NOTICE TO ALL INSUREDS EXCEPT FL, NJ, PA, AND WA: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties, depending upon state law.

IMPORTANT NOTICE FOR FLORIDA RESIDENTS: 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.

NOTICE TO PENNSYLVANIA RESIDENTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application of 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.