Activation Form for GROUP DENTAL INSURANCE for Members of the AMERICAN POSTAL WORKERS UNION (APWU)

Complete this form and return to:
VOLUNTARY BENEFITS PLAN®
P.O. Box 12009
Cheshire, CT 06410

Voluntary Benefits Plan®
Benefits for Members of the
American Postal Workers Union

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

MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

Group Policy G-224,540

Member's Name: ______________________ Social Security Number: ______________
Last Name First Middle Initial

Home Address: ______________________ ______________ ______ ______________
Street City State Zip Code

Home Phone: (____) ____________ E-mail Address: ______________ Local: ____________

Date of Birth: ____ /___ /________ (MM/DD/YYYY)   Sex: ☐ Male ☐ Female   Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

COVERAGE

(Refer to the brochure or your certificate for eligibility, options and coverage descriptions.)

I HEREBY ENROLL IN THE FOLLOWING GROUP DENTAL INSURANCE PLAN: *(Choose one)*

PLAN: ☐ HIGH OPTION ☐ LOW OPTION

INDICATE COVERAGE DESIRED: *(Choose one)*

☐ Member Only ☐ Member & Spouse ☐ Member & Child ☐ Member, Spouse & Child(ren)

If **DEPENDENT** coverage is requested, list eligible dependents
(Lawful spouse and unmarried dependent children under age 19, 25 if a full-time student.) (Subject to state variations.)

SPOUSE'S FULL NAME (Last, First, Mid. Init.)			Social Security Number	Date of Birth / /	☐ Male ☐ Female
1. (Child Name)	Date of Birth / /	☐ Male ☐ Female	3. (Child Name)	Date of Birth / /	☐ Male ☐ Female
2. (Child Name)	Date of Birth / /	☐ Male ☐ Female	4. (Child Name)	Date of Birth / /	☐ Male ☐ Female
5. (Child Name)	Date of Birth / /	☐ Male ☐ Female	6. (Child Name)	Date of Birth / /	☐ Male ☐ Female

OPTIONAL COVERAGE ELECTION *(Available only for eligible dependent children under age 19)*

Do you wish to add Optional Orthodontic Coverage? ☐ Yes ☐ No *(If you check YES your Plan Premium will automatically increase by 10%)*

NOTE: *If both parents are members, child(ren) can only be covered by one parent.*

I hereby enroll for and authorize the necessary salary deductions for the premium to pay for insurance in the Voluntary Benefits Plan Dental Plan underwritten by The United States Life Insurance Company in the City of New York. I further agree to participate in the Dental Plan for a minimum of one year. I understand that coverage applied for shall become effective on the first day of the period my first premium is received following the date of approval.

I have read and understand the conditions and exclusions of the program.

Important Notice – Any person who knowingly and with intent to defraud any insurance company or other person files a 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 may be a crime. (Fraud provisions vary by state.)

______________________________ ____ /___ /_____
Member Signature X *(Sign in ink)* *Date*

Group Policy No. G-224,540

3/13 ***NOTE:*** *If you have made corrections or strikeouts on this enrollment form, the Member MUST initial them.* AG-9953