Dental Insurance Plan Enrollment Card

Security Life Insurance Company of America
PO Box 27810, Mpls, Minnesota 55427-0810

Check Type of Plan: ❑ Individual ❑ Individual + One (1) Eligible Dependent ❑ Individual + Family

			/ / Mo Day Yr	M ❑ F ❑	For Company Use Only
Social Security No.	Last Name	First	Initial	Birthdate	Sex	Effective Date
Home Address				Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced	Plan Code
City, State, Zip		Telephone			

List Below All Eligible Dependents to be covered

Last Name (if different)	First Name	Initial	Sex M F	Birthdate Mo Day Yr
2. Spouse				
3. Child				
4.				
5.				
6.				
7.				

Does Spouse have a dental plan? ❑ Yes ❑ No With whom? _____ If answer is "Yes" are dependents enrolled under spouse's plan? ❑ Yes ❑ No

Do you claim a tax exemption for all eligible dependents listed above? ❑ Yes ❑ No If no, whom do you not claim? _____

All dependent children listed above over Age 18 are full time students? ❑ Yes ❑ No If no, who is not? _____

MONTHLY PREMIUM: $ _____

BILLING MODE: (Choose one)
- ❑ ACH — Bank Account Number _____ → Enclose a check for one month's premium and a voided check
- ❑ VISA — Credit Card Number _____ Expiration Date _____
- ❑ MASTER CARD — Credit Card Number _____ Expiration Date _____

By my signature below, I hereby apply for coverage under SECURITY LIFE GROUP DENTAL INSURANCE POLICY FORM GH-1112.

I hereby authorize that my premiums be charged against my bank or credit card account as indicated above. The authorization remains in effect until revoked by me in writing.

Applicant's Signature	Date	K KNUTSON Agent Name (please print)	41-1993738 Agent TIN	41124 State License Number

INDDENTAPP(7/98)

Mail completed applications to:

MN Health Insurance Network, Inc
1020 E 146th St, Suite 107
Burnsville, MN 55337-6756