

# Dental Insurance Plan Enrollment Form



**The United States Life Insurance Company  
in the City of New York.**  
*A member company of American International  
Group, Inc.*

## To Enroll:

Send this completed form with  
your premium check payable to:  
**PEARL INSURANCE**  
1200 East Glen Avenue  
Peoria Heights, IL 61616-5348

**Questions?**  
1.800.342.6501

PLEASE PRINT IN INK OR TYPE - DO NOT USE CORRECTION FLUID OR GEL PEN - INITIAL AND DATE ANY CHANGES

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F  
(first, middle, last)

Address: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_  
\_\_\_\_\_ ( )  
\_\_\_\_\_ home

City: \_\_\_\_\_ ( )  
\_\_\_\_\_ work

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Eligibility Date: \_\_\_\_\_  
(FOR OFFICE USE ONLY)

## MEMBERSHIP AFFILIATION

I am a member of the New York State Society of CPAs  
 Yes  No Membership #: \_\_\_\_\_

NOTE: Membership in NYSSCPA is required for participation in the plan.

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

Spouse Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(first, middle, last name only if different)

Spouse's Social Security #: \_\_\_\_\_ 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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(first, middle, last name only if different)

Child's Social Security #: \_\_\_\_\_ Sex:  M  F

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(first, middle, last name only if different)

Child's Social Security #: \_\_\_\_\_ Sex:  M  F

**BE SURE TO COMPLETE AND SIGN REVERSE SIDE** ►

## RATE 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 Pearl Insurance. Even if you select Automatic Check Withdrawal, you are required to send a check for your first month's premium along with a blank voided check.

Area \_\_\_\_\_

Member Only \$ \_\_\_\_\_  Member + 1 Child \$ \_\_\_\_\_

Member & Spouse \$ \_\_\_\_\_  Family \$ \_\_\_\_\_

### 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 have read and understand the conditions and exclusions of the program. I hereby enroll in The Dental Plan for New York State Society of CPAs Members. I understand that the insurance enrolled for shall become effective on the date specified by The United States Life Insurance Company 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.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### AUTOMATIC MONTHLY CHECK WITHDRAWAL REQUEST:

By selecting Automatic Monthly 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 application.**

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 INSURED 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 and 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.