

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. I declare all answers are true and complete.	
WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.	
DATE	CITY AND STATE
SIGNATURE OF EMPLOYEE	