



**ENROLLMENT WITH  
AIG American General**  
The United States Life Insurance Company in the City of New York



ADM. USE ONLY
CASE NO.
EMPLOYEE NO.
CLASS
1-
EFFECTIVE DATE
UWF 48
YES NO
DATE _____

(Please type or print in ink) (May be photocopied or duplicated)

FULL NAME OF EMPLOYEE				SEX (M/F)				
RESIDENCE ADDRESS		CITY		STATE		ZIP		
AGE (LAST BIRTHDAY)	BIRTHDATE (MM/DD/YY)	DATE OF HIRE (FULL TIME) (MM/DD/YY)	SOCIAL SECURITY NUMBER					
EMPLOYER'S NAME			AVG. NO. HOURS WORKED WEEKLY		WEEKLY EARNINGS			
EMPLOYER'S LOCATION - STREET ADDRESS			CITY		STATE		ZIP	
EMPLOYER'S PHONE NUMBER (include Area Code)			OCCUPATION AND DUTIES					
MARITAL STATUS	NUMBER OF ELIGIBLE CHILDREN	I AM APPLYING FOR						
<input type="checkbox"/> Self Only <input type="checkbox"/> Self and Children <input type="checkbox"/> Self and Spouse <input type="checkbox"/> Self, Spouse & Children								

ADMIN USE ONLY

Name of all dependents to be insured	Relationship (spouse, son, daughter)	Sex M/F	Date of Birth	Age	Full time student	LATE	T/O	T/O ORTHO	PXT
1.					Y or N		Y or N	Y or N	
2.					Y or N		Y or N	Y or N	
3.					Y or N		Y or N	Y or N	
4.					Y or N		Y or N	Y or N	
5.					Y or N		Y or N	Y or N	

I am working at least 30 hours per week on a regular basis for the above-named employer. I hereby authorize my employer to make the necessary deduction if any is required.

X \_\_\_\_\_ at (City & State) \_\_\_\_\_ on date: \_\_\_\_\_

PLEASE SIGN IN INK

FOR WAIVER OF ELIGIBILITY, COMPLETE REVERSE SIDE

Please mail completed enrollment form to: Allied National, P. O. Box 419254, Kansas City, MO 64141-6254

602s1102



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**WAIVER OF GROUP DENTAL COVERAGE UNDER THE ALLIED GROUP INSURANCE TRUST  
(Underwritten by The United States Life Insurance Company in the City of New York)**

AFTER due consideration, I have chosen:

- Not to enroll my spouse in the Group Dental Plan being offered by my employer.
- Not to enroll my children in the Group Dental Plan being offered by my employer.
- Not to enroll myself and my dependents in the Group Dental Plan being offered by my employer.

I understand that this waiver is permitted only if I am required to contribute premium and only if I, or I and my dependents, are covered under a group Dental Plan.

Name of current insurance carrier \_\_\_\_\_

Insurance carrier phone number \_\_\_\_\_ Case or Plan # \_\_\_\_\_

How do you qualify for this coverage? \_\_\_\_\_

(ex-spouse employer, Retired Military, Medicaid)

I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents. Further, I understand that if I and/or my dependents enroll under this plan in the future, first year benefits may be limited.

Name of Your Employer: \_\_\_\_\_ Case Number: \_\_\_\_\_

Date: \_\_\_\_\_ Name of Employee: \_\_\_\_\_

(Please Print or Type)

Signature of Employee: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

602WAIVER

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(Please Print or Type)

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Social Security Number: \_\_\_\_\_

602WAIVER