



(may be photocopied or duplicated)



AIG/AMERICAN GENERAL
THE UNITED STATES LIFE INSURANCE COMPANY IN THE CITY OF NEW YORK
EMPLOYER ENROLLMENT FOR GROUP COVERAGE

FIRM NAME _____ PHONE () _____

ADDRESS _____ FAX () _____

CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____

- 1. Type of Firm: [] SOLE PROPRIETORSHIP [] PARTNERSHIP [] CORPORATION [] LLC [] NOT-FOR-PROFIT [] OTHER
2. Exact Nature of Employer's Business _____ SIC CODE _____
3. Date company first began operating _____
4. Name of individual employee at business handling insurance details _____
5. Subsidiary or Affiliated Companies - (The employees of the following subsidiary or affiliated companies also request participation):
NAME ADDRESS NATURE OF BUSINESS

6. I hereby certify that there are, as of this date, a total of _____ full-time (30 hours per week) eligible employees (including owner(s), partners, and officers in the employment of this firm). If any class or classes are to be excluded from eligibility describe them briefly. (Such class exclusions must be non-discriminatory.)

7. I understand and agree that only those full-time employees who meet the eligibility requirements are to be included and that participation must be met before the insurance can be made effective. Participation, as outlined in the brochure under the heading "Participation Requirements" must be maintained continuously while insurance is in force to prevent cancellation of coverage. The undersigned employer understands that if participation falls below two (2) employees for three consecutive months, coverage will be automatically terminated at the end of the third month without further notice and without any requirement of expressed notice of termination of coverage.

8. I understand and agree that the following probationary waiting period will apply to all employees of this firm:
A. All present employees actively-at-work on or before the effective date are eligible on completion of:
[] 0 months [] 1 month [] 2 months [] 3 months of active full-time service.
B. All new employees (actively-at-work after the case effective date) shall become eligible on the first day of the month coinciding with or next following the completion of: [] 1 month [] 2 months [] 3 months of active full-time service.

9. I understand and agree that investigation(s) will be made by Allied, now and in the future, to verify the number and names of full-time employees of this firm, and I will furnish with this application, and upon any future request, a current census and State Quarterly Unemployment Tax Report, and any other information requested.

10. I hereby apply for the Allied Horizons™ Dental Design Plan (choose from the following Plan options):

[] Plan I [] Plan II
Takeover: [] Yes [] No Prior Carrier Name _____ Effective date of coverage _____
Orthodontia: [] Yes [] No
Enhanced Benefits: [] Yes [] No (available only to groups enrolling 10 or more employees)

and agree to pay the annual membership fee and monthly administrative billing charge.

- 11. I agree the firm will pay a minimum of 25% of all Employee costs.
12. DESIRED EFFECTIVE DATE: Month _____ Date _____ Year _____. May be any day of the month. All papers must be signed and dated on or before the requested effective date and be received by the Administrator within 5 working days (including the effective date) after that date in complete and acceptable form. No insurance is effective until approved in writing by Allied.
13. I verify that all employees enrolling for coverage are actively at work and working at least 30 hours per week and all employees meet the eligibility requirements as listed on the employer enrollment form.

I verify that the United States Life Insurance Company's benefit plan(s) have been offered to all employees. Completed waivers are attached for those employees and dependents electing not to participate in the plan(s). NOTE: Changes in the Census data may affect previously quoted rates.

To the best of my knowledge and belief, all statements and answers given in this application are true and complete.

I understand and agree that: no agent may change or waive any of the provisions of this application or any plan of insurance; any change or waiver may be made only by the administrator; this application will be accepted or declined partly on the basis of the statements and answers given on this enrollment form; if the insurance contract comprises a part of an employee benefit plan, The United States Life Insurance Company is granted sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The United States Life Insurance Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.

I understand that this enrollment form requests our participation in a Multiple Employer Trust. I agree to be bound by the terms of the trust agreement, a copy of which will be furnished to me upon my request.

Date _____ Signature _____

(Must be signed by Firm Owner, Partner or Officer)

Title _____



MAIL TO:
 AlliedNational
 NEW CASE UNDERWRITING
 P.O. Box 419254
 Kansas City, MO 64146254
 1-800-825-7531

ADMINISTRATORS USE ONLY
CASE # _____

DIST. NAME
 NUMBER

PRODUCER'S INFORMATION

Please Print or Type Legibly:

Producer's Name _____ Kevin J. Hoyle _____
 Allied Producer Number __20937_____
 Agency or Company_Carolina Health Benefits, Inc._____
 Address __11310 Wagonford Lane_____
 City__Charlotte_____ State_NC_____ ZIP __28273_____
 TEL(704) _588-5090_____ FAX (704) 588-7971 _____
 E-Mail Address___khoyle@chbi.com_____
 Pay Commissions To _Agency_____ SSN OR TAX ID # __56-1982060_____

I certify that all of the information contained in **the Employer Enrollment Form** is correct to the best of my knowledge. I have complied with the underwriting rules and have explained in detail the coverage to the new member firm and its employees.

In the event of cancellation of insurance coverage for which I am an agent, I hereby agree to reimburse Allied National for any and all unearned Commissions on such cancelled insurance.

Date Completed _____ Signature of Producer _____ On File _____

RATE CALCULATOR

	AREA _____ BASE RATE	MULTIPLY BY RATE FACTOR	= FINAL RATES (round to nearest dollar)
EMPLOYEE		X	\$
SPOUSE		X	\$
CHILDREN		X	\$
ORTHO FOR CHILDREN		X*	\$

**Use Ortho for Children Rate Factor*

EMPLOYEE CENSUS NAME	FINAL RATES				PREMIUM TOTALS
	EMPLOYEE	SPOUSE	CHILD(REN)	ORTHO FOR CHILDREN	
MONTHLY ADMINISTRATIVE CHARGE					\$15.00
MONTHLY PREMIUM TOTAL					
FIRST MONTH TOTAL COST					