

**MIDWEST SECURITY LIFE INSURANCE COMPANY**

**Group Dental Insurance Enrollment Card**

Name of Employer			Group No.		
Employee Name Last		First	Middle	<input type="checkbox"/> Female	Social Security No.
Home Address Street		City	State	Zip	Date of Birth / /
Date of Employment		Occupation		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Date of Employment		Occupation		If COBRA continuee please give: Qualifying Event: _____ Date of Event: _____	
Check One: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse		<input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee and Family			
List Name, Sex and Date of Birth of each dependent you wish to insure.					
Spouse		Name	Sex	Date of Birth	3.
Children				Name	Sex
1.				4.	
2.				5.	
Are all of the dependent children listed above: Your natural born children who reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No; Claimed on your federal income taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No; Receiving at least 50% support and maintenance from you? <input type="checkbox"/> Yes <input type="checkbox"/> No; Under the age of 19? <input type="checkbox"/> Yes <input type="checkbox"/> No; Not the subject of a divorce decree or court order relating to financial support/insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No; Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No					
CHANGES DESIRED (EXISTING EMPLOYEE) <input type="checkbox"/> Address Change <input type="checkbox"/> Add Dependents <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Date of Marriage (if applicable) _____ <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Other _____ *Please show changes in appropriate section					Office Use Only
MSMK043 0804					

Does spouse have dental coverage?  Yes  No

I authorize my employer to deduct from my earnings the amount to cover my share of the contribution for coverage indicated on the reverse side.

If Yes, list carrier: \_\_\_\_\_

\*I hereby apply to Midwest Security Life Insurance Company for Group Dental Insurance as presented to me.

\*I further represent that I am not presently disabled and I am performing all the duties of my occupation at least 30 hours per week.

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

I have been given an opportunity to apply for Group Dental Insurance, but do not wish this coverage.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Individual's Signature