ASCE | MEMBER INSURANCE

THE PROVIDER IS:
The United States Life Insurance Company in the City of New York,
A subsidiary of American International Group, Inc. (AIG)

To Apply: Please complete this form and return to:
ASCE Member Insurance Program Administrator, 1200 E Glen Ave, Peoria Heights, IL 61616-5348
Questions: Please call 1.800.650.2723

PART I Personal Info

DISCOUNT DENTAL PLAN ENROLLMENT FORM

PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Member Information:

Member's Name ______________________________
Last First Middle Initial

Home Street Address ______________________________

City ____________ State ____________ Zip ____________

Home Phone (______) ____________ Work Phone (______) ____________

E-mail ______________________________ Fax (______) ____________
For internal use only. E-mail address will never be sold or shared.

Please select the type of coverage you would like: ☐ **Member Only** ☐ **Member + 1 (Either Spouse or Children)** ☐ **Family**

	Date of Birth: MO./ DAY / YR.	Social Security #:	Sex:
Member: **If in addition to yourself, you are applying for dependent coverage, complete below as applicable.**	___ /___ /___	☐☐☐-☐☐-☐☐☐☐	☐ M ☐ F
Spouse Name: ____________ (First/MI/Last)	___ /___ /___	☐☐☐-☐☐-☐☐☐☐	☐ M ☐ F
Child* Name: ____________ (First/MI/Last)	___ /___ /___	☐☐☐-☐☐-☐☐☐☐	☐ M ☐ F
Child* Name: ____________ (First/MI/Last)	___ /___ /___	☐☐☐-☐☐-☐☐☐☐	☐ M ☐ F

*If more than two children are enrolling, attach a separate sheet. Please **sign and date** the additional sheet.

2. Membership Affiliation:

Are you now a member of the ASCE? ☐ Yes ☐ No (Association Membership is required for participation in this plan.)

ASCE Membership #____________ Exp. Date: ____________

3. Payment Option Selection: Choose only one.

☐ **Option 1: Direct Billing:** Following your initial billing, you will be billed **Annually**.

☐ **Option 2: Electronic Funds Transfer:** I request and authorize the ASCE Program Administrator to make monthly withdrawals against the account specified on the attached voided check, statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting payments due under this Discount Dental Plan (Enclose a VOIDED check or deposit slip, as applicable).

____
SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

☐ **Option 3: Credit Card:** I authorize payments to be charged to my credit card monthly:

☐ MasterCard Credit Card #____________ Exp. Date____________

☐ Visa ☐ Discover

☐ American Express

____
SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

Be Sure To Complete All Pages and Sign Last Page

PART II Your Signature

4. PLEASE READ AND SIGN:

I have read and understand the conditions and exclusions of the program. I hereby enroll in The Discount Dental Plan for American Society of Civil Engineers Members. I understand that the plan enrolled for shall become effective on the date specified by The United States Life Insurance Company in the City of New York only if this Enrollment Form is accepted and the first payment 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.

Important Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a 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 may be a crime. (Fraud provisions vary by state.)

Member's Signature **X**_______________________________ Date ____________

Spouse's Signature **X**_______________________________ Date ____________
(Necessary only if spouse coverage is requested)

Be Sure To Complete All Pages and Sign Last Page

Group Policy G-175, 906

AG-6247

120186-ASCE-DisDen-Gen