

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

## 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: <small>If in addition to yourself, you are applying for dependent coverage, complete below as applicable.</small>	___/___/___	□□□□-□□-□□□□	<input type="checkbox"/> M <input type="checkbox"/> F
Spouse Name: _____ <small>(First/M/Last)</small>	___/___/___	□□□□-□□-□□□□	<input type="checkbox"/> M <input type="checkbox"/> F
Child* Name: _____ <small>(First/M/Last)</small>	___/___/___	□□□□-□□-□□□□	<input type="checkbox"/> M <input type="checkbox"/> F
Child* Name: _____ <small>(First/M/Last)</small>	___/___/___	□□□□-□□-□□□□	<input type="checkbox"/> M <input type="checkbox"/> 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

**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