

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

**ASCE MEMBER INSURANCE PROGRAM
SCHEDULED DENTAL INSURANCE PLAN ENROLLMENT FORM**

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

PART I Personal Info

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: _____ <small>Name if proposed for insurance (First/MI/Last)</small>	___/___/___	□□□□-□□-□□□□	<input type="checkbox"/> M <input type="checkbox"/> F
Child*: _____ <small>Name if proposed for insurance (First/MI/Last)</small>	___/___/___	□□□□-□□-□□□□	<input type="checkbox"/> M <input type="checkbox"/> F
Child*: _____ <small>Name if proposed for insurance (First/MI/Last)</small>	___/___/___	□□□□-□□-□□□□	<input type="checkbox"/> M <input type="checkbox"/> F

*If more than two children are proposed for insurance, 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 (Choose one):
 Quarterly Semiannually Annual

Option 2: Electronic Funds Transfer: I request and authorize the ASCE Group Insurance Program 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 premium contributions due under this Scheduled Dental Insurance 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 premium contributions 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 Scheduled 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 premium 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

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