



**ALLIED NON-MEDICAL
EMPLOYEE ENROLLMENT FORM**
(Please type or print in ink - May be copied or duplicated)

1. Employee Information

FULL NAME OF EMPLOYEE				MARITAL STATUS	# OF ELIGIBLE CHILDREN	GENDER (M/F)	ADM. USE ONLY CASE NO. EMPLOYEE NO. CLASS BENEFITS TDLS XS EFFECTIVE DATE UWF 48 YES NO DATE _____
RESIDENCE ADDRESS		CITY	STATE	ZIP			
AGE (LAST BIRTHDAY)	BIRTHDATE (MM/DD/YY)	DATE OF HIRE (FULL TIME)	SOCIAL SECURITY NUMBER				
EMPLOYER NAME			AVG. # HOURS WORKED WEEKLY	GROSS MONTHLY EARNINGS \$			
EMPLOYER'S LOCATION - STREET ADDRESS		CITY	STATE	ZIP			
EMPLOYER'S PHONE NUMBER (include Area Code)		OCCUPATION, TITLE, DUTIES					
<input type="checkbox"/> I AM <input type="checkbox"/> I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER OF THE ABOVE EMPLOYER							

2. Benefit Information

I am applying for (check one) <input type="checkbox"/> Self Only; <input type="checkbox"/> Self & Spouse; <input type="checkbox"/> Self & Child(ren); <input type="checkbox"/> Self, Spouse & Child(ren)
I elect (check all that apply): <input type="checkbox"/> Dental <input type="checkbox"/> Life Insurance <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability

3. Dependent Information

If enrolling for dependent Dental coverage – please list all dependents below

Names of all Dependents to be Insured	Relationship (spouse, son, daughter)	Sex M/F	Date of Birth	Age	Full time student	ADMIN USE ONLY			
						LAT	D&R T/O	Ortho D&R	PXT
	EMPLOYEE								
1.					Y or N				
2.					Y or N				
3.					Y or N				
4.					Y or N				
5.					Y or N				

4. Life Insurance Beneficiary Information

Life Insurance Beneficiary _____ Relationship _____

I am working the average number of hours shown above on a regular basis for the above-named employer. I hereby authorize my employer to make the necessary payroll deduction.

Signature _____ Date _____

PLEASE SIGN IN INK

Please mail completed enrollment form to: Allied National, P. O. Box 29187, Shawnee Mission, KS 66201-9187

FOR WAIVER OF ELIGIBILITY, COMPLETE REVERSE SIDE

(may be photocopied or duplicated)
WAIVER OF GROUP DENTAL COVERAGE

AFTER due consideration, I have chosen:

- Not to enroll myself and/or my dependents in the Group Dental Plan being offered by my employer.
- Not to enroll my spouse in the Group Dental Plan being offered by my employer.
- Not to enroll my children in the Group Dental Plan being offered by my employer.

Please answer the following:

1. I and/or my dependents are covered under another employer-sponsored dental benefit (if you or your spouse are covered under an employer-sponsored plan, please provide the following information) YES NO

Employer Name: _____

Name of current insurance carrier above: _____

Insurance carrier phone number: _____ Case or Plan Number: _____

2. I and/or my dependents are covered under an individual dental plan..... YES NO

3. I opt not to apply for coverage for myself and/or my dependents in the Group Dental Plan due to reasons other than having any existing coverage as listed above. I understand that I have the right to apply for coverage at this time and am voluntarily declining coverage. YES NO

I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents. Further, I understand that if I and/or my dependents enroll under this plan in the future, first year benefits may be limited.

Name of Your Employer: _____ Case Number: _____

Date: _____ Name of Employee: _____

(Please Print or Type)

Signature of Employee: _____

Social Security Number: _____