ABI CareSelect Dental Plan

Enrollment Form

The United States Life Insurance Company in the City of New York
New York, New York

Yes! Please enroll me in the **ABI CareSelect Dental Plan**
Exclusively for members of the American Bar Association

Member Name ____

Address ____

City ______________________ State __________ Zip ______________________

PLEASE COMPLETE THE FOLLOWING

Member Date of Birth _____/_____/_________ ☐ Male ☐ Female

Member Social Security No. _______________ Daytime Phone No. (_____) _______________

INDICATE COVERAGE DESIRED (check only one):

- ☐ Member Only
- ☐ Member & Spouse/Domestic Partner
- ☐ Member & Child(ren)
- ☐ Entire Family

OPTIONS DESIRED

☐ Orthodontia Coverage – Dependent Children (benefits begin in plan year three)

PAYMENT OPTION

☐ Electronic Funds Transfer:
☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ Direct Bill:
☐ Quarterly ☐ Semi-Annually ☐ Annually

Note: A $1.50 billing fee is added to all direct bill options.

DEPENDENT INFORMATION (if applying):

Spouse/Domestic Partner Name ____

Date of Birth ___/___/___ Social Security No. _______________

CHILDREN (eligible children include your unmarried, dependent children up to age 19 years, 25 if a full-time student):

Name ____________________ Date of Birth ___/___/___ Social Security No. _______________

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Name ____________________ Date of Birth ___/___/___ Social Security No. _______________

Name ____________________ Date of Birth ___/___/___ Social Security No. _______________

I hereby enroll with The United States Life Insurance Company in the City of New York for coverage under the ABI CareSelect Dental Plan. I have read and understand the conditions and exclusions of the program. I understand that the insurance applied for shall become effective on the first day of the month after receipt and acceptance of my Enrollment Form and first monthly premium payment.

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 language varies by state.)

____________________	___/___/___	____________________	___/___/___
Member's Signature	*Date*	*Spouse/Domestic Partner's Signature (if applying)*	*Date*

Just complete this enrollment form and return it today!

Please mail your enrollment form, along with a check for your first monthly premium (regardless of the payment option selected), made payable to the plan administrator, Selman & Company. If you selected premium payment via electronic funds transfer, please complete the enclosed authorization form and attach a voided check from the account to be used.