

**AMERICAN  
GENERAL  
ASSURANCE COMPANY**

Products Underwritten by: The United States Life Insurance Company

**GROUP ENROLLMENT FORM**

PLEASE PRINT

**Completing Your GROUP ENROLLMENT FORM**

- Fully complete** each applicable section and **sign and date** Refusal/Authorization Sections, as applicable.
- If applying for **medical** coverage, please: **(A)** Note that the requirements of the pre-existing conditions provision of the group policy will be reduced to the extent that they were satisfied for a pre-existing conditions provision of a previous plan, as defined, if the coverage under the previous plan ended no more than 63 days prior to the date you become insured under the group policy and **(B) Submit a copy of your Certificate(s) of Health Plan Coverage with this enrollment request.** Without your Certificate(s) of Health Plan Coverage, you, and your insured dependents, may be required to satisfy the full extent of any applicable pre-existing conditions exclusion provision under the plan.

**1. PERSONAL DATA: (Must always be completed)**

Group No.		Div. No.		Social Security No.				Last Name			First Name			Initial	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM DD YY		Street Address					City			State	Zip Code			
Name of Employer							Location				Salary \$ Per _____				
Occupation				Title				Date of Full-Time Employment		MM	DD	YY	No. Hours Worked Per Week _____		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Dependent Children <input type="checkbox"/> No <input type="checkbox"/> Yes		If Yes, # _____											

**2. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)**

I was given the opportunity to enroll in this plan of group insurance offered by my employer/association and insured by UNITED STATES LIFE.

I am refusing:

<input type="checkbox"/> All Coverages Offered*	<input type="checkbox"/> Employee & Dependents	<input type="checkbox"/> Employee & Dependents	<input type="checkbox"/> Employee & Dependents	<input type="checkbox"/> Employee & Dependents
<input type="checkbox"/> Life / AD&D	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
<input type="checkbox"/> STD <input type="checkbox"/> LTD	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> Other: _____	<input type="checkbox"/> All Dependents	<input type="checkbox"/> All Dependents	<input type="checkbox"/> All Dependents	<input type="checkbox"/> All Dependents

**ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD MAJOR MEDICAL OR DENTAL COVERAGE:**

Are you or your dependents now covered by any other group plan?  YES  NO (Your dependent(s) may be insured by this Plan even if they are insured elsewhere)

If yes: Policyholder's Name \_\_\_\_\_ Carrier \_\_\_\_\_

I understand that if I am refusing major medical and/or vision insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of the other applicable insurance plan.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.

I must furnish, at my expense, **evidence of insurability** satisfactory to United States Life if I later wish to enroll in any other coverage that is now being refused.

DATE OF REFUSAL

SIGNATURE IF REFUSING ANY COVERAGE

\*IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.

**3. ENROLLMENT:**

If enrolling for Medical, Dental, Vision or Prescription Drug benefits, list name, relationship to you, date of birth and Social Security Number of each dependent to be insured. PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.

Name	Relationship			Date of Birth MM/DD/YY	Sex	Social Security Number	Give policy number, name and address of other carrier, (including Medicare), that you or your dependents may have been insured with in the last 6 months. Indicate effective and termination dates.
	Self	Sp.	Ch.				
SELF	X						<b>DO NOT COMPLETE.</b>

**4. DENTAL OPTION ELECTED: Complete this section if you are enrolling in a Dental Plan that requires you to select a benefit option (ULTRA CHOICE, COMPREHENSIVE VOLUNTARY OR FLORIDA VOLUNTARY DENTAL plans only).**

<input type="checkbox"/> <b>Ultra Choice Dental (New York, New Jersey only)</b>	<input type="checkbox"/> <b>Comprehensive Voluntary Dental (New York, New Jersey only)</b>	<input type="checkbox"/> <b>Florida Voluntary Dental</b>
<input type="checkbox"/> Reasonable & Customary Option	<input type="checkbox"/> High Option	<input type="checkbox"/> Reimbursement Option
<input type="checkbox"/> Comprehensive Option	<input type="checkbox"/> Low Option	<input type="checkbox"/> Economy Option
<input type="checkbox"/> EPO Option		

If you are enrolling in the **Comprehensive Option** of the **Ultra Choice** plan, or the **Comprehensive Voluntary Dental** plan, (any option), indicate Dentist's Name and Code Number: \_\_\_\_\_ Dentist's Code No. \_\_\_\_\_

**5. BENEFICIARY DESIGNATION: (Complete only if applying for Life/AD&D benefits)**

EX: MARY A. JONES, WIFE NOT MRS. JOHN JONES	First Name	Initial	Last Name	Relationship
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**6. AUTHORIZATION:**

- I hereby certify that all information furnished is true to the best of my knowledge.
- I request group insurance for which I am or may become eligible.
- If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to United States Life.
- I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death.
- If health care is provided by a participating provider, all benefits will be paid directly to the provider by United States Life, (Participating Provider Organization Plans only).
- I authorize any physician or medical professional, any hospital, clinic, any insurer or employer to give to United States Life or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to my employment, other insurance coverage and medical care, advice, treatment or supplies for any physical or medical condition.

DATE SIGNED

APPLICANT'S SIGNATURE

HOME OFFICE USE — DENTAL ENROLLMENTS	<input type="checkbox"/> EMPLOYEE ONLY	<input type="checkbox"/> EMPLOYEE + SPOUSE	<input type="checkbox"/> EMPLOYEE + CHILD	<input type="checkbox"/> EMPLOYEE + SPOUSE + CHILD
DENTAL BENEFITS (COMPLETE IF COMPREHENSIVE):	PREV: <input type="checkbox"/> YES <input type="checkbox"/> NO	DENTAL UNIT _____	ORTHO: <input type="checkbox"/> YES <input type="checkbox"/> NO	
POINT-OF-SERVICE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLAN NAME: _____	COVERAGE EFFECTIVE DATE: _____		