



To Apply: Please complete this form and return to: REAGIT Group Insurance Program Administrator, 1200 E Glen Ave, Peoria Heights, IL 61616-5348
Questions: Please call 1.800.222.9958 or visit www.dentemax.com

REAGIT GROUP DENTAL INSURANCE 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:

Full Name (First, Middle Initial, Last), SS #, Street Address, City, State (or Province), Zip Code, Home Phone, Work Phone, Fax, Email, Marital Status, Date of Birth, Height, Weight, Sex for Member, Spouse, and Child.

2. Membership Affiliation:

Are you now a member of the Appraisal Institute? Yes No (Association Membership is required for participation in this plan.) Appraisal Institute Membership # Exp. Date:

3. Payment Option Selection: Choose only one.

- Option 1: Direct Billing: Following your initial billing, you will be billed twice a year on January 1 and July 1.
Option 2: Electronic Funds Transfer: I request and authorize the REAGIT Group Insurance Program to make monthly/quarterly/semiannual/annual 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 Group 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 premium contributions to be charged to my credit card monthly/quarterly/semiannual/annually: Credit Card # Exp. Date MasterCard Visa Discover American Express

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

4. Insurance Requested: Refer to plan information for eligibility, options and coverage description.

I HEREBY APPLY FOR THE FOLLOWING GROUP DENTAL INSURANCE COVERAGE:

- A. Desired Coverage: MEMBER OPTION: MEMBER & FAMILY OPTION
B. Benefit Level: PLAN 1 (high option) PLAN 2 (low option)

I hereby enroll with The United States Life Insurance Company in the City of New York for coverage under the REAGIT Group Dental Plan. I have read and understand the conditions and exclusions of the program. I understand that the insurance applied for shall become effective the first day of the calendar quarter after my enrollment form is received.

Member s Signature X Date (PLEASE SIGN AND DATE IN INK)

Do Not Send Payment: Upon approval, you will be notified of the premium due.

Group Policy No. V-233,612