



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, Member, Spouse, Child information.

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, Option 2: Electronic Funds Transfer, Option 3: Credit Card. Includes fields for signature, date, and credit card details.

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.

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