

# Group Dental Insurance Plan Enrollment Form

Underwritten by The United States Life Insurance Company in the City of New York  
 Executive Office: P.O. Box 667, Wilmington, Delaware 19899-9853 (302) 594-2000



1. Select the type of plan and billing frequency you prefer.
2. Complete the personal information requested.
3. Print, sign, date and return enrollment form along with payment to: ASRT Insurance Program Administrator  
 159 East County Line Road  
 Hatboro, PA 19040-9635

## 1. BENEFIT PLAN SELECTION

Choose coverage for:  Member Only  Member & Spouse/Domestic Partner  Member & Dependent Child(ren)  
 Family Coverage (including Member, Spouse/Domestic Partner and Child(ren))

## 2. PERSONAL INFORMATION (PLEASE PRINT)

Name: \_\_\_\_\_ Membership #: \_\_\_\_\_  
 Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email address: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Sex:  Male  Female  
 Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Please complete the following if you are enrolling for Family Coverage

Name	Date of Birth	Social Security Number
SPOUSE/DOMESTIC PARTNER		
CHILD		
CHILD		

\* Children must be unmarried and under age 19; age 25 if a full time student (subject to state variations).  
 Attach a separate piece of paper, if you are enrolling more than 2 children.

## 3. BILLING OPTION SELECTION

**OPTION 1: Electronic Funds Transfer**  Monthly  Quarterly  Semi-Annual  Annual

### Authorization for Electronic Funds Transfer

I request and authorize Affinity Insurance Services, Inc. (LifeHealth) to make withdrawals based on my selected payment method above against the account specified on the attached voided check or 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 plan. **In order to process your electronic payment, both the Account # and Bank Routing # must both appear on the voided check or deposit slip.** I understand that by completing the required information regarding my enrollment I am authorizing automatic deductions/charges for the insurance premium from my account.

The premium, based on the plan I selected, will be deducted from or charged to my account as indicated above unless I call the plan administrator to cancel. I understand that I must contact the plan administrator if I wish to cancel these automatic deductions/charges or if I wish to cancel my insurance coverage.

I also understand that my authorization for the deduction is not part of my certificate of insurance, nor does it modify any terms or conditions contained therein. The insurance company is not liable if the financial institution dishonors any amount deducted/charged and may terminate my insurance coverage immediately if premium for my insurance is not paid. Payment of the initial premium is one of the conditions required in order for my coverage to be placed in effect. I understand that if the deduction/charge is declined for any reason, my coverage will not take effect.

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

**OPTION 2: Direct Bill**  Quarterly  Semi-Annual  Annual (Make check payable to: Affinity Insurance Services, Inc.)

I hereby enroll with The United States Life Insurance Company in the City of New York for coverage under the ASRT Group Dental Insurance 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 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 provisions vary by state.)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Spouse/Domestic Partner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (If enrolling)

G-19477-CA

Please see next page for compensation disclosure information

Group Policy No: V-610,210  
 AG8662

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**Please complete the enrollment form and return it with payment to:**

ASRT Insurance Program Administrator  
159 East County Line Road  
Hatboro, PA 19040-9635

**Don't let an unanswered question delay your enrollment.**

**Call toll free: 1-877-212-8334**  
**[www.asrtinsurance.com](http://www.asrtinsurance.com)**

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#### **COMPENSATION and OTHER DISCLOSURE INFORMATION**

Life & Health, a division of Affinity Insurance Services, Inc., exclusively offers the Group Dental Insurance Program as an agent of The United States Life Insurance Company in the City of New York and provides services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

As compensation for the services described above, Affinity receives 17% of your paid premium. In addition, Affinity may charge a fee for administrative services. For mid-term premium bearing coverage endorsements and renewal policies, Affinity is compensated at the same levels as the initial policy commission, unless we notify you otherwise. Your signature on your application, quote form, check, and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Aon.

Other than the commissions described in the preceding paragraph, Affinity will receive no other compensation from the insurer.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. These investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon website at [http://www.aon.com/market\\_relationships](http://www.aon.com/market_relationships) for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interests.

#### **Contracts and Agreements**

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit [http://www.aon.com/market\\_relationships](http://www.aon.com/market_relationships) for more detail on these agreements.

The underwriting risks, financial and contractual obligations and support functions associated with products issued by The United States Life Insurance Company in the City of New York (United States Life) are its responsibility.

The ASRT Insurance Program is administered by Aon Affinity, a division of Affinity Insurance Services, Inc.; in CA, MN & OK, a division of AIS Affinity Insurance Agency, Inc.; and in NY a division of AIS Affinity Insurance Agency. CA License #0795465. AR License #244489.