



**ENROLLMENT WITH
AIG American General**
Policy issued by the The United States Life Insurance Company
in the City of New York
A subsidiary of American International Group, Inc. (AIG) New York, New York



(Please type or print in ink) (May be photocopied or duplicated)

FULL NAME OF EMPLOYEE				SEX (M/F)			
RESIDENCE ADDRESS		CITY		STATE		ZIP	
AGE (LAST BIRTHDAY)	BIRTHDATE (MM/DD/YY)	DATE OF HIRE (FULL TIME) (MM/DD/YY)	SOCIAL SECURITY NUMBER				
EMPLOYER'S NAME			AVG. NO. HOURS WORKED WEEKLY		WEEKLY EARNINGS \$		
EMPLOYER'S LOCATION - STREET ADDRESS		CITY		STATE		ZIP	
EMPLOYER'S PHONE NUMBER (include Area Code)			OCCUPATION AND DUTIES				
MARITAL STATUS	NUMBER OF ELIGIBLE CHILDREN	I AM APPLYING FOR <input type="checkbox"/> Self Only <input type="checkbox"/> Self and Children <input type="checkbox"/> Self and Spouse <input type="checkbox"/> Self, Spouse & Children					

ADM. USE ONLY
CASE NO.
EMPLOYEE NO.
CLASS 1-
BENEFITS T D L S
EFFECTIVE DATE
UWF 48 YES NO DATE _____

ADMIN USE ONLY

Name of all dependents to be insured	Relationship (spouse, son, daughter)	Sex M/F	Date of birth	Age	Full time student	LATE	T/O	T/O ORTHO	PXT
1.	EMPLOYEE				Y or N		Y or N	Y or N	
2.					Y or N		Y or N	Y or N	
3.					Y or N		Y or N	Y or N	
4.					Y or N		Y or N	Y or N	
5.					Y or N		Y or N	Y or N	

I am working at least 30 hours per week on a regular basis for the above-named employer. I hereby authorize my employer to make the necessary deduction if any is required.

X _____ at (City & State) _____ on date: _____

PLEASE SIGN IN INK FOR WAIVER OF ELIGIBILITY, COMPLETE REVERSE SIDE
Please mail completed enrollment form to: Allied National, P. O. Box 29187, Shawnee Mission, KS 66201-9187

602s0808 00850006-3640 R11/04



**ENROLLMENT WITH
AIG American General**
Policy issued by the The United States Life Insurance Company
in the City of New York
A subsidiary of American International Group, Inc. (AIG) New York, New York



(Please type or print in ink) (May be photocopied or duplicated)

FULL NAME OF EMPLOYEE				SEX (M/F)			
RESIDENCE ADDRESS		CITY		STATE		ZIP	
AGE (LAST BIRTHDAY)	BIRTHDATE (MM/DD/YY)	DATE OF HIRE (FULL TIME) (MM/DD/YY)	SOCIAL SECURITY NUMBER				
EMPLOYER'S NAME			AVG. NO. HOURS WORKED WEEKLY		WEEKLY EARNINGS \$		
EMPLOYER'S LOCATION - STREET ADDRESS		CITY		STATE		ZIP	
EMPLOYER'S PHONE NUMBER (include Area Code)			OCCUPATION AND DUTIES				
MARITAL STATUS	NUMBER OF ELIGIBLE CHILDREN	I AM APPLYING FOR <input type="checkbox"/> Self Only <input type="checkbox"/> Self and Children <input type="checkbox"/> Self and Spouse <input type="checkbox"/> Self, Spouse & Children					

ADM. USE ONLY
CASE NO.
EMPLOYEE NO.
CLASS 1-
BENEFITS T D L S
EFFECTIVE DATE
UWF 48 YES NO DATE _____

ADMIN USE ONLY

Name of all dependents to be insured	Relationship (spouse, son, daughter)	Sex M/F	Date of birth	Age	Full time student	LATE	T/O	T/O ORTHO	PXT
1.	EMPLOYEE				Y or N		Y or N	Y or N	
2.					Y or N		Y or N	Y or N	
3.					Y or N		Y or N	Y or N	
4.					Y or N		Y or N	Y or N	
5.					Y or N		Y or N	Y or N	

I am working at least 30 hours per week on a regular basis for the above-named employer. I hereby authorize my employer to make the necessary deduction if any is required.

X _____ at (City & State) _____ on date: _____

PLEASE SIGN IN INK FOR WAIVER OF ELIGIBILITY, COMPLETE REVERSE SIDE
Please mail completed enrollment form to: Allied National, P. O. Box 29187, Shawnee Mission, KS 66201-9187

602s0808 00850006-3640 R11/04

(may be photocopied or duplicated)
WAIVER OF GROUP DENTAL COVERAGE

(Policy issued by the The United States Life Insurance Company in the City of New York. A subsidiary of American International Group, Inc. (AIG) New York, New York)
AFTER due consideration, I have chosen:

- Not to enroll myself and/or my dependents in the Group Dental Plan being offered by my employer.
- Not to enroll my spouse in the Group Dental Plan being offered by my employer.
- Not to enroll my children in the Group Dental Plan being offered by my employer.

Please answer the following:

1. I and/or my dependents are covered under another employer-sponsored dental benefit (if you or your spouse are covered under an employer-sponsored plan, please provide the following information) YES NO

Employer Name: _____

Name of current insurance carrier above: _____

Insurance carrier phone number: _____ Case or Plan Number: _____

2. I and/or my dependents are covered under an individual dental plan YES NO

3. I opt not to apply for coverage for myself and/or my dependents in the Group Dental Plan due to reasons other than having any existing coverage as listed above. I understand that I have the right to apply for coverage at this time and am voluntarily declining coverage. YES NO

I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents. Further, I understand that if I and/or my dependents enroll under this plan in the future, first year benefits may be limited.

Name of Your Employer: _____ Case Number: _____

Date: _____ Name of Employee: _____

(Please Print or Type)

Signature of Employee: _____

Social Security Number: _____

602s0608

(may be photocopied or duplicated)
WAIVER OF GROUP DENTAL COVERAGE

(Policy issued by the The United States Life Insurance Company in the City of New York. A subsidiary of American International Group, Inc. (AIG) New York, New York)
AFTER due consideration, I have chosen:

- Not to enroll myself and/or my dependents in the Group Dental Plan being offered by my employer.
- Not to enroll my spouse in the Group Dental Plan being offered by my employer.
- Not to enroll my children in the Group Dental Plan being offered by my employer.

Please answer the following:

1. I and/or my dependents are covered under another employer-sponsored dental benefit plan (if you or your spouse are covered under an employer-sponsored plan, please provide the following information) YES NO

Employer Name: _____

Name of current insurance carrier above: _____

Insurance carrier phone number: _____ Case or Plan Number: _____

2. I and/or my dependents are covered under an individual dental plan YES NO

3. I opt not to apply for coverage for myself and/or my dependents in the Group Dental Plan due to reasons other than having any existing coverage as listed above. I understand that I have the right to apply for coverage at this time and am voluntarily declining coverage. YES NO

I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents. Further, I understand that if I and/or my dependents enroll under this plan in the future, first year benefits may be limited.

Name of Your Employer: _____ Case Number: _____

Date: _____ Name of Employee: _____

(Please Print or Type)

Signature of Employee: _____

Social Security Number: _____

602s0808