BROKERS NATIONAL LIFE ASSURANCE COMPANY

GROUP DENTAL INSURANCE ENROLLMENT CARD

NAME OF EMPLOYER People Lease

GROUP # 14327

EMPLOYEE NAME — LAST — FIRST — MIDDLE

☐ FEMALE ☐ MALE

HOME ADDRESS — STREET — CITY — STATE — ZIP CODE

HOME TEL. NO. ( )

DATE OF BIRTH / /

SOCIAL SECURITY NUMBER

EMPLOYMENT DATE

MARITAL STATUS

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

(CHECK ONE):

☐ EMPLOYEE ONLY ☐ EMPLOYEE AND ONE DEPENDENT ☐ EMPLOYEE AND FAMILY

WORK 30 HOURS PER WEEK?

☐ YES ☐ NO

LIST NAME, SEX AND DATE OF BIRTH OF EACH DEPENDENT YOU WISH TO INSURE
STUDENT VERIFICATION MUST ACCOMPANY DEPENDENTS OVER 18.

NAME	REL.	SEX	DATE OF BIRTH	FULL-TIME STUDENT?	NAME	REL.	SEX	DATE OF BIRTH	FULL-TIME STUDENT?
				Y / N					Y / N
				Y / N					Y / N
				Y / N					Y / N

☐ I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS THE AMOUNT TO COVER MY SHARE OF THE CONTRIBUTION FOR COVERAGE INDICATED ABOVE.

SIGNATURE OF EMPLOYEE

DATE

REQUESTED EFFECTIVE DATE

(CHECK ONE):

☐ PLAN A ☐ PLAN B ☐ BASIC

DOMICILED IN THE STATE OF ARKANSAS • ADMINISTRATIVE OFFICE: 7010 HWY 71 WEST, STE. 100, AUSTIN, TEXAS 78735 • PHONE: 512-383-0220

WAIVER OF COVERAGE

I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR GROUP DENTAL INSURANCE, BUT:

- ☐ DO NOT WISH THIS COVERAGE.
- ☐ AM COVERED UNDER SPOUSE'S DENTAL PLAN.
- ☐ MY SPOUSE HAS OTHER COVERAGE.

Date____, ____

Individual's Signature

For Home Office Use Only

Plan __________ State__________ FR#___________EPSI# _________WP___________ OE ___________ Effective Date _______________

Notes:

Writing Agent Name____ Agent # ___________________________________

Splitting Agent Name____ Agent # ___________________________________