PLEASE PRINT AND COMPLETE IN FULL TO AVOID DELAY OR INELIGIBILITY.

LIBERTY UNION LIFE ASSURANCE COMPANY EMPLOYEE ENROLLMENT APPLICATION

☐ NEW EMPLOYEE ☐ REINSTATEMENT ☐ DEPENDENT CHANGE ☐ NAME CHANGE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE HIRED FULL-TIME	? MALE ? FEMALE	? MARRIED ? SINGLE	**CLASS**

EMPLOYEE'S NAME — **GROUP NUMBER**

LAST FIRST INITIAL

EMPLOYEE'S ADDRESS — **EFFECTIVE DATE**

STREET CITY STATE ZIP

? IF DEPENDENT COVERAGE IS DESIRED YOU MUST COMPLETE ?

LAST	FIRST	INITIAL	RELATIONSHIP	SEX	DATE OF BIRTH
			SPOUSE		

IS SPOUSE EMPLOYED? ? YES ? NO	SPOUSE'S EMPLOYER	DOES SPOUSE HAVE OTHER DENTAL COV? ? YES ? NO	SPOUSE'S CARRIER NAME & ADDRESS	SPOUSE'S GROUP NUMBER

I HEREBY AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTIONS, IF ANY ARE REQUIRED.

SIGNATURE DATE

AVERAGE HRS WORKED PER WEEK	OCCUPATION		EMPLOYER NAME
FORMER LAST NAME	DATE OF MARRIAGE	DATE OF DIVORCE	

PLEASE COMPLETE BELOW IF YOU WISH TO REFUSE DENTAL BENEFITS FOR YOURSELF OR YOUR DEPENDENTS.

WAIVER SECTION

I have been given an opportunity to apply for benefits through my Employer but, after due consideration, have decided NOT to take advantage of:

Benefits As Provided	For Myself	For My Dependents
All Dental Benefits	☐	☐

I understand that if I enroll at a later date I may be subject to Penalties or Limitations as described in the Policy. I also understand that if a benefit is excluded for myself, it will also be excluded for any eligible dependent(s).

SIGNATURE _____ DATE _____