

Enrollment Form for Discount Dental Plan

For members of *The American Ceramic Society*

Underwritten by *The United States Life Insurance Company in the City of New York*,
A member company of *American International Group, Inc.*



Please print or type all information requested.

Plan Selection: Member Member & Spouse Member & Child(ren) Family

Member's Full Name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address	City	State	Zip
Social Security No.		Date of Birth	
Home Phone ()		Work Phone ()	

Complete the following for spouse and/or children, if applying for insurance. Use a separate sheet of paper if more space is needed.

	Name	Date of Birth* (mm/dd/yy)	Social Security Number
Spouse			
Child			
Child			
Child			
Child			

*Unmarried, dependent children under 19 years of age (25 if full-time student) are eligible to enroll for coverage under this plan. (Subject to state variations.)

I hereby enroll with The United States Life Insurance Company in the City of New York, a member company of American International Group, Inc. for coverage under ACERS Discount Dental Plan. I have read and understand the conditions and exclusions of the program.

I understand that the plan applied for shall become effective on the first day of the following month if enrollment material and payment are received on the first through the fifteenth day of the month or the first day of the month following the month after receipt of payment and enrollment material if enrollment material and payment are received of the sixteenth through the thirty-first day of the month.

Important Notice: Any person who knowingly and with intent to defraud any insurance company of 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 of Member: _____ **Date:** ____ / ____ / ____

Signature of Spouse (if applying): _____ **Date:** ____ / ____ / ____

To enroll, please complete this enrollment form, sign, date and return it with your first annual payment check made payable to Selman & Company:

ACERS Members' Insurance Program
6110 Parkland Boulevard, Cleveland, Ohio 44124
800-556-7614