

# Assurant Employee Benefits Application Form

**Please retain a copy of this  
application for your records**

AGENT NUMBER

4D07574

Your Social Security Number	Last Name	First Name	Middle I.	Sex	M <input type="checkbox"/> F <input type="checkbox"/>	<b>IMPORTANT</b> Write the Dental Facility Number of the dentist(s) you choose from the directory in the space(s) below.
Your Date of Birth	Address					
Home Phone	City	State	Zip Code+4			

List Dependents to be Enrolled						Dental Facility Number			
First Name	Middle I.	Last Name (if different)	Relationship	Date of Birth	Sex				
Spouse					M <input type="checkbox"/> F <input type="checkbox"/>				
Child					M <input type="checkbox"/> F <input type="checkbox"/>				
Child					M <input type="checkbox"/> F <input type="checkbox"/>				

Attach a separate sheet of paper for additional children.

<b>Prepayment Fee Amount</b> \$ _____ <b>+Enrollment Fee</b> \$ 35.00 <b>Total Enclosed \$</b> _____	<input type="checkbox"/> <b>Annual Payment</b> - make the check payable to Fortis Benefits Insurance Company. <input type="checkbox"/> <b>Charge my annual prepayment fees</b> <input type="checkbox"/> <b>Automatic Monthly Bank Draft</b> - complete the Authorization Agreement on the reverse side of this form.	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover Exp. Date    Mo. _____ Yr. _____ _____
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By my signature below, I understand that this Individual Prepaid Dental Plan is a non-refundable one (1) year program. I also understand that a full description of the plan will be provided in the Individual Dental Service Agreement and that the dentist I select may or may not perform all of the procedures listed on the Copayment Schedule. I authorize the dentist who has rendered procedures to me or members of my family to make available to Fortis Benefits my dental records, photocopies or information regarding such procedures to the extent permitted by law. It is a crime to knowingly provide false, incomplete or misleading information for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of benefits. This authorization is not governed by HIPAA; however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Fortis Benefits Insurance Company and its affiliated dental companies to use and disclose protected health information.

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_ Subscriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

10.40 16.74 25.68  
 109.82 185.86 293.15  
 BDC-IAPP-STD

This is an important document that will become part of your contract. Benefits administered by Fortis Benefits Insurance Company and provided by one or more of the following companies: Alabama - DentiCare of Alabama, Inc., Kansas and Missouri - United Dental Care of Missouri, Inc.

# Authorization Agreement For Automatic Monthly Bank Draft

Name(s)	Social Security Number																	Checking <input type="checkbox"/> Savings <input type="checkbox"/>
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**IMPORTANT**

If you selected the Monthly Bank Draft Payment method, enclose a voided check, your first month's prepayment fee and \$35 enrollment fee with this form and send them to us.

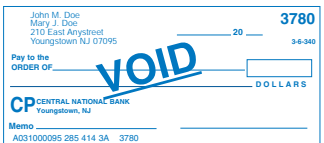
I (we) hereby authorize Fortis Benefits Insurance Company to initiate debit entries, and to initiate if necessary, credit entries and adjustments for any debit entry corrections to my (our) account indicated below and the Financial Institution named below to debit and/or credit same to such account.

Bank Name	City	State
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**Include your Checking or Savings Account Number in the boxes below:**

Account Number																	
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**Prepayment fees are deducted from your authorized account on the 15th of the month prior to the month of benefits. The Authorization Agreement automatically renews if the Individual Dental Service Agreement renews.**



This authorization is to remain in full force and effective until Fortis Benefits Insurance Company has received WRITTEN notification from me (or either of us) of its termination by the 10th of the month prior to the month when the enrollment is to be terminated.

Signature \_\_\_\_\_ Date \_\_\_\_\_