AIG AMERICAN GENERAL

Group Employee Enrollment Form

The United States Life Insurance Company in the City of New York
Member of American International Group, Inc.
New York, New York

American General Assurance Company
Member of American International Group, Inc.
Schaumburg, IL

*American General Assurance Company is not admitted in New York

Completing Your **GROUP ENROLLMENT FORM**

1. **Fully complete** each section. **Sign and date** Refusal/Authorization Section, as needed.

1. PERSONAL DATA: (Must always be completed)

Group No.	Div. No	Class	Social Security No.	Last Name	First Name	Initial

Sex ☐ Male ☐ Female | Date of Birth MM DD YY | Street Address | City | State | Zip Code

Name of Employer | Location | Salary $ _____ Per _____

Occupation | Title | Date of Full-Time Employment MM DD YY | No. Hours Worked Per Week _____ ☐ Union ☐ NonUnion

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Dependent Children ☐ No ☐ Yes If Yes, # _____

2. ENROLLMENT

If enrolling for Dental or Vision benefits, list name, relationship to you, date of birth and Social Security Number of each dependent to be insured.
PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.

Give policy number, name and address of current employer's prior group insurance carrier, if you and your dependents were insured. Indicate your effective and termination dates of coverage also.

Name	Relationship Self	Sp.	Ch.	Date of Birth MM/DD/YY	Sex	Social Security Number
SELF	X					

3. DENTAL OPTION ELECTED: Complete this section if your are enrolling in a Dental Plan that requires you to select a benefit option (DUAL OPTION, COMPREHENSIVE VOLUNTARY OR FLORIDA VOLUNTARY DENTAL plans only).

☐ **Dual Option Dental (New York, New Jersey only)**
☐ Reimbursement Option
☐ Comprehensive Option

☐ **Comprehensive Voluntary Dental (New York, New Jersey only)**
☐ High Option ☐ Medium Option
☐ Low Option ☐ Economy Option

☐ **Florida Voluntary Dental**
☐ Reimbursement Option
☐ EPO Option

If you are enrolling in the **Comprehensive Option** of the **Dual Option Dental** plan, or the **Comprehensive Voluntary Dental** plan, (any option), indicate Dentist's Name and Code Number: Dentist's Name: _____ Dentist's Code No. _____
Date Prior Dental Coverage Took Effect: _____

4. Supplemental Life Benefit: If this benefit is a plan option and you wish to enroll for Supplemental Life coverage, please indicate

The amount $

5. Beneficiary Designation: as is

EX: MARY A. JONES, WIFE NOT MRS. JOHN JONES	First Name	Initial	Last Name	Relationship

6. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)

I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by UNITED STATES LIFE.

I am refusing:
☐ LTD
☐ STD
☐ Life/AD&D
☐ Dependent Life
☐ Supplemental Life/AD&D
☐ All coverages offered

Dental:
☐ Employee & Dependents
☐ Spouse
☐ Child(ren)
☐ All Dependents

Vision:
☐ Employee & Dependents
☐ Spouse
☐ Child(ren)
☐ All Dependents

Medical/Prescription Drug:
☐ EE Dependents
☐ Spouse
☐ Children
☐ All Dependents

MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:
Are you or your dependents now covered by any other group plan? ☐ YES ☐ NO (Your dependent(s) may be insured by this Plan

If Yes: Policyholder's Name _____ Carrier _____ even if they are insured elsewhere)

I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of other other applicable insurance plan.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.
I must furnish, at my expense, **evidence of insurability** satisfactory to United States Life if I later wish to enroll in any other coverage that is now being refused.

_____ _____
DATE OF REFUSAL *SIGNATURE IF REFUSING ANY COVERAGE*

***IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.**

7. AUTHORIZATION:

- I hereby certify that all information furnished is true to the best of my knowledge.
- I request group insurance for which I am or may become eligible.
- If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to American General Assurance Company.
- I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death.
- If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by American General Assurance Company.
- I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give to American General Assurance Company information about me. Such information will pertain to my employment or other insurance coverage.

_____ _____
DATE SIGNED *APPLICANT'S SIGNATURE*

Please mail this form to: 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754