

Planholder Name (Company Name) University Medical/Dental Resident Services, P.C.		Group Plan No.	Division	Class
Planholder Street Address		City	State	Zip
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced			DEPENDENT CHILDREN: <input type="checkbox"/> YES <input type="checkbox"/> NO	
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION CHANGE: <input type="checkbox"/> INCREASE <input type="checkbox"/> ADD DEPENDENT(S)/RIDER(S) <input type="checkbox"/> PREMIUM CLASS				
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED				
Name (Last, First, Middle Initial)		Sex	Birthdate	Employee's Social Security #
Employee:		<input type="checkbox"/> M <input type="checkbox"/> F		
Spouse:		<input type="checkbox"/> M <input type="checkbox"/> F		Date of Marriage / /
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
(1) Are any dependent children adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name and date of placement:				
(2) Have you included stepchildren? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name(s):				
Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of Full Time Employment	Hrs. Worked / Week	Annual Salary \$	Occupation /Job Title	Beneficiary Name (Last, First, Middle), Relationship and %
Employee's Street Address			City	1. _____ %
State	Zip	Business Phone #	Home Phone #	2. _____ %
LONG TERM DISABILITY				
<input checked="" type="checkbox"/> Coverage has been paid for you by your company if you meet eligibility requirements.				
DENTAL				
<input checked="" type="checkbox"/> Coverage has been paid for you and your family by your company if you meet eligibility requirements.				
Check box if you have a Spouse and/or Child(ren):				
<input type="checkbox"/> Spouse				
<input type="checkbox"/> Child(ren)				
<ul style="list-style-type: none"> • I hereby apply for the group benefit(s) indicated above. • I understand I must be actively at work or my coverage will not take effect and my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. • I understand that insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex. • I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance. • The information provided above is true and correct to the best of my knowledge. • Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation (does not apply to life insurance). 				
X SIGNATURE OF EMPLOYEE				DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN