MADISON NATIONAL LIFE INSURANCE COMPANY, INC. – P.O. Box 20593, Indianapolis, Indiana

EMPLOYEE DENTAL INSURANCE APPLICATION

PLEASE PRINT IN SPACE PROVIDED

EMPLOYER INFORMATION

EMPLOYER NAME	LOCATION	GROUP NO.

EMPLOYEE

LAST NAME	FIRST NAME		M.I.
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ( )		BIRTH DATE / /

SEX	EMPLOYMENT DATE	MARITAL STATUS	OCCUPATION/TITLE	EMPLOYMENT STATUS
MALE ☐ FEMALE ☐	MM / DD / YY	SINGLE ☐ MARRIED ☐		ACTIVE ☐ INACTIVE ☐

COVERAGE – Check Those That Apply (Note: If declining coverage(s), complete the section REFUSAL/WAIVER only

Dental Insurance

☐ EMPLOYEE ☐ SPOUSE ☐ CHILDREN REQUESTED EFFECTIVE DATE: ____________

DEPENDENT INFORMATION

SPOUSE NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE?____________________
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:
____

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE DENTAL COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN

REASON FOR REFUSAL:____

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

DATE	CITY AND STATE

SIGNATURE OF EMPLOYEE