



EMPLOYEE ENROLLMENT FORM

Dental Policy Coverage by Ameritas Life Insurance Corp.
Dental Trust Coverage by Kansas City Life Insurance Company
Life and Disability coverage by Security Financial Life Insurance Co.



Please type or print in ink - May be copied or duplicated

1. Employee Information

Form with fields for Employee Last Name, Residence Address, Age, Employer Name, etc.

ADM. USE ONLY table with fields for Case No., Employee No., Class, Effective Date, UWF 48, etc.

2. Dental Enrollment - Complete for All Dental Plans

I wish to enroll in the Dental plan provided through my employer. I am enrolling for:

- Self Only, Self and Spouse Only, Self and Children Only, Self, Spouse and Children

If enrolling for dependent Dental coverage - please list all dependents below

Table with columns: Names of Dependents to Insure, Relationship, Sex, DOB, Social Security Number, LAT, D&R, Ortho D&R, PXT

3. Life Insurance/Disability Insurance Enrollment

A. I wish to enroll in the following employer paid benefit plans at the benefit levels set by my employer:

- Life/AD&D, Short-Term Disability, Long-Term Disability

B. VOLUNTARY/SUPPLEMENTAL COVERAGE - Complete this information ONLY if you are applying for voluntary or supplemental coverage.

I wish to enroll in the following voluntary or supplemental payroll deduction/Section 125 benefit plans offered by my employer (benefit amounts available limited by plan rules at enrollment)

- Term Life and AD&D: Employee Benefit \$, Spouse Benefit \$, Children Benefit \$
Short-Term Disability: Fixed Benefit Amount \$ OR Percent of Salary %
Long-Term Disability: Fixed Benefit Amount \$ OR Percent of Salary %

C. Life Insurance Beneficiary Relationship

I am working at least 30 hours per week on a regular basis for the above-named employer. I hereby authorize my employer to make the necessary payroll or Section 125 deduction. I understand benefit elections made under Section 125 can only be changed during annual open enrollment or because of a qualifying event.

Signature Date

PLEASE SIGN IN INK

FOR WAIVER OF ELIGIBILITY, COMPLETE REVERSE SIDE

Please mail completed enrollment form to: Allied National, P. O. Box 419254, Kansas City, MO 64141-6254

(May be photocopied or duplicated)

WAIVER OF GROUP DENTAL COVERAGE (Underwritten by Ameritas Life Insurance Corporation or Kansas City Life Insurance Company)

AFTER due consideration, I have chosen:

- Not to enroll myself and my dependents in the Group Dental Plan being offered by my employer.
- Not to enroll my spouse in the Group Dental Plan being offered by my employer.
- Not to enroll my children in the Group Dental Plan being offered by my employer.

I understand that this waiver is permitted only if I am required to contribute premium and only if I, my dependents or I and my dependents, are covered under my spouse's employer's group Dental Plan.

My spouse's employer is _____
(Name of Spouse's Employer)

My spouse's employer's phone number is _____
(Spouse's Employer's Phone Number - Including Area Code)

and such employer's group Dental Plan is insured or underwritten by _____
(Name of Insurance Company or Plan Name)

I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents. Further, I understand that if I and/or my dependents enroll under this plan in the future, benefits will reduced for my first year of coverage.

Name of Your Employer: _____ Case Number: _____

Date: _____ Name of Employee: _____

(Please Print or Type)

Signature of Employee: _____

Social Security Number: _____