

# ABI CareSelect Dental Plan

## Enrollment Form

The United States Life Insurance Company in the City of New York

A subsidiary of American International Group, Inc. (AIG)

New York, New York

**Yes!** Please enroll me in the **ABI CareSelect Dental Plan**  
*Exclusively for members of the American Bar Association*

(NAME)  
(HOME ADDRESS)  
(ABA ID #)

DE02-10-01

### PLEASE COMPLETE THE FOLLOWING

Member Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Male  Female

Member Social Security No. \_\_\_\_\_ Daytime Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_

### INDICATE COVERAGE DESIRED (check only one):

- Member Only
- Member & Spouse
- Member & Child(ren)
- Member, Spouse & Child(ren)

### OPTIONS DESIRED

- Orthodontia Coverage  
(dependent children only; benefits begin in plan year three)

### PAYMENT OPTION

- Monthly (via Electronic Funds Transfer only)
- Quarterly
- Semi-annual
- Annual

Note: A \$1.50 billing fee is added to non-monthly billing.

### DEPENDENT INFORMATION (if applying):

Spouse Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security No. \_\_\_\_\_

### CHILDREN (eligible children include your unmarried, dependent children up to age 19 years, 25 if a full-time student):

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I hereby enroll with The United States Life Insurance Company in the City of New York, a subsidiary of American International Group, Inc. (AIG), for coverage under the ABI CareSelect Dental Plan. I have read and understand the conditions and exclusions of the program. I understand that the insurance applied for shall become effective on the first day of the month after receipt and acceptance of my Enrollment Form and first premium payment. I certify that I am actively at work as defined in the brochure.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Member's Signature Date Spouse's Signature (if applying) Date

## Just complete this enrollment form and return it today!

Please mail your enrollment form, along with a check for your first monthly premium (regardless of the payment option selected), made payable to "American Bar Insurance." If you selected monthly premium payments via electronic funds transfer, please complete the enclosed authorization form and attach a voided check from the account to be used.