AIG AMERICAN GENERAL

**Employee Enrollment**

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

New York, NY
A member company of American International Group, Inc.
Administrative Office: PO Box 2727, Houston, TX 77018
800-207-9224 or 713-365-9524 (Fax)

| Social Security Number | Last Name | First | Initial | Birth Date<br>Month/Day/Year | Sex<br>❑ M<br>❑ F | For Company Use Only<br>Requested Effective Date |
|---|---|---|---|---|---|---|
| Home Address | | | | | Marital Status<br>❑ Single<br>❑ Married | Waiver |
| City, State and Zip Code | | | | Telephone | | Group No. |
| Employer Name and Location | | | | Employment Date<br>Month/Day/Year | | Employment Status<br>❑ Active ❑ Inactive |
| Occupation/Title | | | | Coverage<br>❑ Employee<br>❑ Employee + Spouse<br>❑ Employee + Children<br>❑ Employee + Family | | |

| List Dependent Information<br>Last Name (if different) First Name Initial | Sex M/F | Birth Date | List Dependent Information<br>Last Name (if different) First Name Initial | Sex M/F | Birth Date |
|---|---|---|---|---|---|
| 2. Spouse | | | 5. | | |
| 3. Child | | | 6. | | |
| 4. | | | 7. | | |

| Does any dependent have dental coverage?<br>❑ Yes ❑ No | With whom? | All dependent children listed above, over the age of 19, are full-time students: ❑ Yes ❑ No |
|---|---|---|
| I decline coverage for:<br>❑ Myself ❑ My Spouse ❑ My Children | Reason for refusal: | |

I hereby request coverage as outlined above for AIG American General's group dental plan, underwritten by The United States Life Insurance Company in the City of New York, a member company of American International Group, Inc. I authorize my employer to deduct from my earnings, including any future adjustments and required contributions. I reserve the right to revoke or change this authorization by written notice and understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverages, treatments, and services I may receive may be distributed and disclosed to my employer, and I hereby consent to the dissemination and disclosure of all information. I declare all answers true and complete.

Applicant's Signature ______________________________ Date ______________

City ______________________________ State ______________________________