

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Dental Application

Last Name	First Name	MI

- New Application
- Change Card

Home Address	City, ST	ZIP

Home Phone	Employer/Group /Association	Emp/Grp?Assoc.Phone

Select Payment Mode

- Group Billing
- Annual Direct Billing
- Semi Annual Direct Billing
- Quarterly Direct Billing
- Monthly Bank Draft

Primary Employee/Member	SSN	DOB	Marital Status	Sex

This authorization will draft monthly payments from my checking account. A voided blank check is enclosed on the bank on which the drafts are to be drawn.

Dependent Name	DOB	Relationship	Sex	Student (Y/N)

Monthly Credit Card

- Visa
- Master Card

Credit Card #

Exp. Date

I understand and agree that the insurance shall not take effect unless the application has been accepted and approved by the Company and until the Effective Date of the Certificate. *Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.*

Signature of Employee/Member	Check with Application? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	Eff. Date	Plan Code STDENT
Agent Sign And Complete		Group Code	Rate Code	Rate