

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Dental Application

Last Name	First Name	MI

Home Address	City, ST	ZIP

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

Primary Employee/Member	SSN	DOB	Marital Status	Sex

Dependent Name	DOB	Relationship	Sex	Student (Y/N)

***Are all dependent children between the ages 19 and 24 full-time students (Y/N) "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."**

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any Company, makes any claim for the proceeds of an insurance Policy containing any false, incomplete or misleading information is guilty of a felony.

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

- New Application
- Change Card

- Select Payment Mode**
- Group Billing
 - Annual Direct Billing
 - Semi Annual Direct Billing
 - Quarterly Direct Billing
 - Monthly Bank Draft

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.

- Monthly Credit Card**
- Visa
 - Master Card

Credit Card #

Exp. Date