

Assurant Employee Benefits Application Form

Please retain a copy of this application for your records

AGENT NUMBER

Your Social Security Number: _____ Middle I. _____ Sex M F

Your Date of Birth: / / Address _____

Home Phone: () _____ City _____ State _____ Zip Code+4 _____

IMPORTANT
Write the Dental Facility Number of the dentist(s) you choose from the directory in the space(s) below.

List Dependents to be Enrolled	First Name	Middle I.	Last Name (if different)	Relationship	Date of Birth	Sex	Dental Facility Number
Spouse					/ /	M <input type="checkbox"/> F <input type="checkbox"/>	
Child					/ /	M <input type="checkbox"/> F <input type="checkbox"/>	
Child					/ /	M <input type="checkbox"/> F <input type="checkbox"/>	

Attach a separate sheet of paper for additional children.

Prepayment Fee Amount \$ _____

Enrollment Fee \$ 35.00

Total Enclosed \$ _____

Annual Payment - make the check payable to Fortis Benefits Insurance Company

Charge my annual prepayment fees

Automatic Monthly Bank Draft

complete the Authorization Agreement on the reverse side of this form

Visa MasterCard American Express Discover

Exp Date: / /

By my signature below, I understand that this Individual Prepaid Dental Plan is a non-refundable one (1) year program. I also understand that a full description of the plan will be provided in the Individual Dental Service Agreement and that the dentist I select may or may not perform all of the procedures listed on the Copayment Schedule. I authorize the dentist who has rendered procedures to me or members of my family to make available to Fortis Benefits Insurance Company and its affiliated dental companies my dental records, photocopies or information regarding such procedures to the extent permitted by law. Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. This authorization is not governed by HIPAA; however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Fortis Benefits Insurance Company and its affiliated dental companies to use and disclose protected health information.

Agent's Signature _____ Date _____ Subscriber's Signature _____ Date _____

12.24 19.84 30.57
131.82 223.08 351.86
BDC-IAPP-TN

This is an important document that will become part of your contract. Benefits provided by and administered by Fortis Benefits Insurance Company.