

How to Enroll in Pearl Dental Insurance Plans

1. Complete the Dental Insurance Enrollment Form below.
2. Complete the payment method section.
3. Return your completed form and check (made payable to **United States Life**) to Administrator:
Pearl Insurance, 1200 East Glen Avenue, Peoria Heights, IL 61616-5348

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

FOR COMPANY USE ONLY

EFFECTIVE DATE
PLAN CODE
WAIVER CPT
GROUP #
DIVISION #

DENTAL INSURANCE ENROLLMENT FORM

ENROLL ME IN THE: SENIOR GOLD PLAN Policy V-610,239 SENIOR SILVER PLAN Policy V-610,238

LAST NAME	FIRST	M. I.
HOME ADDRESS		
CITY	STATE	ZIP
PHONE		
NAME OF PROFESSIONAL ASSOCIATION YOU BELONG TO (IF APPLICABLE)		
EMPLOYER		
EMPLOYER ADDRESS <input type="checkbox"/> (CHECK TO HAVE NOTICES MAILED TO EMPLOYER ADDRESS)		
CITY	STATE	ZIP
PHONE		
EMAIL		

DATE OF BIRTH	<input type="radio"/> MALE <input type="radio"/> FEMALE
Marital Status:	<input type="radio"/> MARRIED <input type="radio"/> SINGLE <input type="radio"/> WIDOWED <input type="radio"/> DIVORCED
Please bill my:	<input type="radio"/> RESIDENCE <input type="radio"/> EMPLOYER
Applying for coverage of:	<input type="radio"/> APPLICANT <input type="radio"/> APPLICANT + 1 <input type="radio"/> APPLICANT + FAMILY
Does spouse have a dental plan?	<input type="radio"/> YES <input type="radio"/> NO
With whom?	_____
If "Yes," are dependents enrolled under spouse's plan?	<input type="radio"/> YES <input type="radio"/> NO
Proof of full-time student status must be submitted for children between ages 19-23.	

List below all dependents to be covered:

LAST NAME (IF DIFFERENT)	FIRST	M. I.	SEX	DATE OF BIRTH
SPOUSE:				/ /
CHILD:				/ /
CHILD:				/ /
CHILD:				/ /

Important Notice - 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 may be a crime. (Fraud provisions vary by state.)

APPLICANT'S SIGNATURE _____
DATE _____

AG-6938

PAYMENT METHOD SECTION

Electronic Funds Transfer (EFT)—Save \$14.00 per Year:

Enjoy the convenience of having your premium payment automatically withdrawn each month and the assurance that your coverage will not lapse due to a late payment. Complete the authorization agreement below. For checking account withdrawals, **include a voided blank check**. Write "VOID" across the blank check. Complete the premium calculation section for monthly EFT. Remit your check (made payable to **United States Life**) to Pearl Insurance for the first two monthly premiums and the EFT administration fee. Future premiums will be deducted from your checking or savings account.

Premium calculation for monthly EFT

- Determine your monthly premium according to the area/rate chart
\$ _____ X 2 = \$ _____
- EFT administration fee @ \$.50 per month \$ 1.00
- **Total remittance to begin EFT** \$ _____

Quarterly Direct Bill:

Direct billing is available on a quarterly basis. The quarterly billing dates are January, April, July, and October. If your coverage effective date falls in the middle of a quarter, your premium will be prorated. Complete the premium calculation section for quarterly direct bill. Remit your check (made payable to **United States Life**) to Pearl Insurance for the total remittance due.

Premium calculation for quarterly direct bill

- Determine your monthly premium according to the area/rate chart
\$ _____ X 3 = \$ _____
- Quarterly direct bill administration fee \$ 5.00
- **Total remittance to begin quarterly direct bill** \$ _____

AUTHORIZATION AGREEMENT TO DRAFT BANK ACCOUNT

Please complete the following information:

1. **My Account is:**
 - Checking (include voided check)
 - Savings (include deposit slip or copy of account statement)
2. **Name of Bank or Institution:** _____
3. **Account #:** _____

I hereby authorize you to electronically charge my account for premium debits to The United States Life Insurance Company in the City of New York, c/o Pearl Insurance, Peoria Heights, Illinois. I understand my account will be charged according to my billing due date. The deduction will be made on the first of each month. I agree that this electronic payment shall be regarded the same as if a check was written by me and drawn on my account. This authorization is to remain in effect until revoked by me in writing. I understand that this authorization may be terminated: (1) at the option of Pearl Insurance if any debt is not honored when presented for payment, or (2) upon thirty (30) days' written notice given by Pearl Insurance, the bank, or me.

APPLICANT'S SIGNATURE _____ DATE _____

PRODUCER INFORMATION

NOTE:

If you have written business with The United States Life Insurance Company in the City of New York/Pearl Insurance in this State during the calendar year, just complete your name and Tax ID and sign below. There is no need to submit a copy of your license with every case.

PRODUCER NAME

ADDRESS

CITY

STATE

ZIP

()

PHONE

EMAIL

TAXPAYER # OR SOCIAL SECURITY #

PEARL INSURANCE AGENT ID # (IF ASSIGNED)

INSURANCE LICENSE #

Insurance license attached:

YES

NO

Are you currently appointed with United States Life?

YES

NO

PRODUCER SIGNATURE

Pearl Insurance

GENERAL AGENT