



AFTRA SUPPLEMENTAL DENTAL AND VISION INSURANCE ENROLLMENT FORM

PLANHOLDER NAME (COMPANY NAME) AFTRA c/o Group Benefit Associates		GROUP PLAN NO. 396684	
PLANHOLDER STREET ADDRESS 3963 W. Belmont Ave., Ste. 6		CITY Chicago	STATE IL
		ZIP CODE 60618	
MEMBER'S NAME (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER	BIRTH DATE
			SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
MEMBER'S STREET ADDRESS		CITY	STATE
			ZIP
		TELEPHONE 1 () -	
Email Address	Requested Effective Date of Coverage (Must be the first of month)		TELEPHONE 2 () -
AFTRA Union Membership Number (Performer ID)			
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED			DEPENDENT CHILD(REN): <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT ENROLLMENT FOR INSURANCE (Check appropriate box.)			
I Elect Dependent Coverage For: <input type="checkbox"/> spouse only <input type="checkbox"/> spouse & child(ren) <input type="checkbox"/> child(ren) only			
LIST EACH DEPENDENT NAME (LAST, FIRST, MIDDLE INITIAL)	SEX	RELATIONSHIP	BIRTH DATE
	<input type="checkbox"/> F <input type="checkbox"/> M		
	<input type="checkbox"/> F <input type="checkbox"/> M		
	<input type="checkbox"/> F <input type="checkbox"/> M		
	<input type="checkbox"/> F <input type="checkbox"/> M		
Are any dependent children adopted? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes," indicate name & date of adoption _____			
Have you included stepchildren as dependents? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes" indicate name/s _____			
Do your stepchildren reside with you? <input type="checkbox"/> YES <input type="checkbox"/> NO Are they dependent upon you for support and maintenance? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Authorization:			
<ul style="list-style-type: none"> • I hereby apply for the group benefit(s) that I have chosen above. • I understand that I must meet eligibility requirements for all coverage's that I have chosen above. • I hereby authorize Babbitt Municipalities, Inc. (d.b.a. Group Benefit Associates) to draft or charge my account for the purpose of collecting premiums for AFTRA Supplemental Dental and Vision insurance policy I have accepted to participate in. • The collection of premium will occur on the 15th of the month prior to the start of the next quarter. • I accept the payment conditions and wish to enroll. • I attest that the information provided above is true and correct to the best of my knowledge. 			
Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false deceptive statement may be guilty of insurance fraud.			
Signature of AFTRA Member X			Date

Both sides of form must be filled out completely in order to process the enrollment.



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Payments are drafted on the 15th of the month or the next business day if the 15th falls on a weekend or bank holiday. Drafts will occur on the 15th of September, December, March, and June. All premiums are collected electronically. There will be NO invoicing of premium.

Please Select Payment Method:		
<input type="checkbox"/> Checking Account	Name on account as it appears on check:	
	Bank Name:	
	Routing Number (9 digits):	
	Account Number:	

<input type="checkbox"/> Visa	Name as it appears on card:	
	Credit Card Number:	
	Expiration (MM/YY):	
	Card Security Code (last 3 digits on back of card):	

<input type="checkbox"/> MasterCard	Name as it appears on card:	
	Credit Card Number:	
	Expiration (MM/YY):	
	Card Security Code (last 3 digits on back of card):	

Signature of premium payer

Date

I hereby authorize Babbitt Municipalities, Inc. (d.b.a. Group Benefit Associates) to draft my credit card or bank account as listed above on or near the 15th of each quarter for the purpose of collecting premiums for the AFTRA Dental and Vision Program I have accepted.

Both sides of form must be filled out completely in order to process the enrollment.