

Fidelity Security Life Insurance Company			Dental Enrollment Form			Policy No DT-111, DT-128		
Last Name, First Name, Initial			Social Security Number		Birth Date		Sex	
Home Address			Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>					
City		State	Zip Code		Applying for coverage Applicant only <input type="checkbox"/> Applicant+One <input type="checkbox"/> Applicant+Family <input type="checkbox"/>			
Billing Address (if different)			Telephone Number			Email Address		
City		State	Zip Code		Requested Effective Date			
Dependents to be covered Last Name, First Name, MI		Sex	Birth Date		Dependents to be covered Last Name, First Name, MI		Sex	Birth Date
1. Spouse					3. Child			
2. Child					4. Child			
Are any applicants (including dependents) covered under another dental plan?					<input type="checkbox"/> Yes <input type="checkbox"/> No			
If "YES", Carrier Name: _____								
Will that other dental plan be terminated upon issuance of this dental plan?					<input type="checkbox"/> Yes <input type="checkbox"/> No			
All dependent children listed, over age {18}, {22 in North Dakota} are full-time students:					<input type="checkbox"/> Yes <input type="checkbox"/> No			
If "NO" who isn't? _____								
California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Notice: If you or your family members are covered by more than one dental plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors or hospitals, and it may be impossible to comply with both plans at the same time. Read all rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.								
Underwritten by: Fidelity Security Life Insurance Company A-00997(5/05)		The certificate provides dental benefits only. Review your certificate carefully. I hereby represent that the above information is complete and accurate to the best of my knowledge and belief. {I understand and acknowledge that by applying for this group insurance I am also becoming a member of the United Associations of American Group Insurance Trust or a member of The National Voluntary Benefit Trust.} {I here by represent that I have reviewed the fraud warning notice (if applicable) on the reverse side of this application fro my state of residence.} Applicant's Signature _____ Date _____						

Premium Calculation	Agent Information
Adult Premium \$ _____ X Number of Adults _____ = \$ _____	Name:
Child Premium \$ _____ X Number of Children _____ = \$ _____	Company:
Total Premium: \$ _____	SSN/Tax ID
Plus Monthly Admin. Fee \$ 6.00	Address
Plus One Time Enrollment Fee \$ 5.00	City, State, Zip
TOTAL DUE WITH APPLICATION \$ _____	Phone
	Fax
	E-Mail
	Pay Commissions to
	Signature

Underwritten & Administered by:
 Fidelity Security Life Insurance Company, Kansas City MO
 Distributed by:
 Marketing Benefits, Inc.,
 P O Box 1459, Orange Beach, AL 36561,
 Phone: 800-811-1600, Email: bill@marketingbenefits.com

**Make checks payable to Fidelity Security Life Insurance Company
 and RETURN all forms and checks to:**

General Agent:
National Insurance Markets, Inc
915 Saxonburg Blvd. Suite 217
Pittsburgh, PA 15223
412-782-1979/1-800-235-2013