



# MCL Premier Dental Insurance Plan

Official Enrollment Form

Please print or type. Complete all areas, sign, and date.

Member Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

**M10WEBXP**

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

Daytime Telephone Number: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

MCL Membership Number: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

*Return your Enrollment Form in the enclosed postage-paid reply envelope or mail to:*

**MCL Premier Dental Insurance Plan**  
P.O. Box 153046  
Irving, TX 75015-3046

**Administered and Marketed by:**  
National Employee Benefit Companies, Inc. (NEBCO)  
Irving, Texas

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

E-mail address: \_\_\_\_\_

## Dependent Information: Complete if family members are to be insured.

Name of Spouse: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

Spouse's Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Name of Child\*: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

Name of Child\*: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

Name of Child\*: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

*\* Children must be unmarried and under age 19; (25 if a full-time student).  
If enrolling for more than 3 children, please attach a separate piece of paper, signed and dated.*

## Enclosed is my Quarterly Premium Payment which includes a \$3.00 Administrative Fee for:

- Single Member ..... \$102.00
- Member and One Dependent ..... \$180.00
- Member and Two or More Dependents ..... \$242.00

I hereby enroll with The United States Life Insurance Company in the City of New York, for coverage under the MCL Premier Dental Insurance Plan. I have read and understand the conditions and exclusions of the program. I understand that the coverage requested shall become effective on the first day of the month **AFTER** receipt of my Enrollment Form and First Premium Payment.

**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.)

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(If enrolling)*

**Please make your check payable to NEBCO**

Group Policy No. V-610,110  
AG-7881