



**To enroll:** Complete, sign, date and return this enrollment form, **with your 3-month premium payment\* made payable to Selman & Company, to:** Selman & Company, Group Insurance Administrator, 6110 Parkland Boulevard, Cleveland, OH 44124-4187.

(\*Subsequent premium deductions will be taken as elected on the Enrollment Form below.)

**MEMBER INFORMATION**

**Are you a new Addison Avenue Federal Credit Union Member?**  Yes  No

- If **yes**, what is your membership effective date?: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- If **no**, you must wait for the next open enrollment period to apply (see [addisonavenue.com](http://addisonavenue.com) for details).

Member Name:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married (check one) <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.:		Date of Birth: / /
Address:			
City:		State:	Zip:
Daytime Phone: ( )		Email Address:	
Date of Retirement: / /			

**COVERAGE DESIRED** (check only one):

- Member Only     Member & Spouse     Member & Child     Member, Spouse & Child(ren)

**DEPENDENT INFORMATION** (only if applying):

Spouse Name:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.:	Date of Birth: / /
<b>Eligible children include your unmarried, dependent children up to age 19 years, 25 if a full-time student):</b>		
Child 1 Name:	Date of Birth: / /	
Child 2 Name:	Date of Birth: / /	
Child 3 Name:	Date of Birth: / /	

**PAYMENT INFORMATION**

**Account Deduction Authorization:** Please complete the enclosed **Account Payment Option Authorization Form.**

I authorize an automatic deduction from the following account: (Please choose one.)

**Checking** Please attach a sample **VOIDED** check.

**Savings** Account Number: \_\_\_\_\_ Routing Number: \_\_\_\_\_

**Modal Deduction Should Be Taken:**  Quarterly  Semi-Annually  Annually

-OR-

I hereby authorize the necessary credit card deduction for the Dental Coverage:

<b>Bill My Credit Card:</b> <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	<b>Card Number:</b>	<b>Modal Deduction Should Be Taken:</b> <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually
Name as it appears on Card		Exp. Date: / /
Cardholder's Signature:		Date of Birth: / /

I hereby enroll with The United States Life Insurance Company in the City of New York, a subsidiary of American International Group, Inc. (AIG), for coverage under the Family Choice<sup>SM</sup> Voluntary Indemnity Group Dental Insurance Plan. I have read and understand the conditions and exclusions of the program. I understand the coverage applied for shall become effective on the first day of the month after receipt of my enrollment form AND payment of my first modal premium made payable to Selman & Company.

*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.)*

<b>Member's Signature:</b>	Date: / /
<b>Spouse's Signature (if applying):</b>	Date: / /