

QCD "RED" Plus Program

QCD "WHITE" Program

QCD "BLUE" Plan

MADISON NATIONAL LIFE INSURANCE COMPANY, INC. – P.O. Box 20593, Indianapolis, IN 46220

**EMPLOYEE DENTAL INSURANCE APPLICATION**

PLEASE PRINT IN SPACE PROVIDED

<b>EMPLOYER INFORMATION</b>			
EMPLOYER NAME		LOCATION	GROUP NO.
<b>EMPLOYEE</b>			
LAST NAME		FIRST NAME	M.I.
STREET ADDRESS		CITY	STATE ZIP
SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ( )	BIRTH DATE / /
SEX MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>	OCCUPATION/TITLE EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>
<b>COVERAGE – Check Those That Apply (Note: If declining coverage(s), complete the section REFUSAL/WAIVER only)</b>			
<b>Dental Insurance</b>			
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> ONE <input type="checkbox"/> FAMILY      REQUESTED EFFECTIVE DATE: _____			
<b>DEPENDENT INFORMATION</b>			
SPOUSE NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	
WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _____ IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER: _____			
<b>REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent</b>			
I DECLINE DENTAL COVERAGE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY CHILDREN REASON FOR REFUSAL: _____			
<b>ACKNOWLEDGMENT AND AUTHORIZATION</b>			
I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.			
WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.			
DATE	CITY AND STATE		
SIGNATURE OF EMPLOYEE			

QCD of America  
 12222 Merit Drive  
 Suite 1070  
 Dallas, Texas 75251  
 972-726-0444 or 800-229-0304  
 972-726-0448 (Fax)



# THE "RED" PROGRAM GROUP ENROLLMENT FORM

Please complete all information and sign. PLEASE PRINT all information.

### SUBSCRIBER INFORMATION

New QCD Member
  Existing QCD Member Making Changes

Last Name	First Name	MI	Date of Birth
Address		City	State      Zip
Social Security Number		Telephone	
Company Name		Effective Date	

### COVERAGE SELECTED

**Employee Only**  
 **Employee + One Dependant**  
 **Employee + Household**

### DEPENDENT INFORMATION

Social Security Number	Last Name	First Name	MI	Date of Birth	Gender	Relationship

I hereby make application for membership in QCD of America® (QCD). I agree to hold QCD harmless from any liability for negligence on the part of the Affiliated Dentist. I further release QCD from and waive any claims for negligent referral, negligent certification or similar claim. I hereby authorize my employer to make payroll deductions, if required, for the coverage selected. The QCD of America Dental and Vision Benefit Program is not an insurance plan and does not constitute insurance coverage.

\_\_\_\_\_ Date \_\_\_\_\_ Applicant Signature

I hereby waive enrollment in the dental/vision coverage through QCD for the current Plan Year.

Date	Employee Name (Printed)
Employee Signature	Employee Social Security Number