



SCMA Members' Insurance Trust

A subsidiary of the South Carolina Medical Association

P.O. Box 11188 • 132 Westpark Boulevard • Columbia, SC 29211
Telephone (803) 798-6207 • 1-800-327-1021 ext. 237, 239, 425 • Fax (803) 731-4021

DENTAL APPLICATION

Effective Date _____

1. Name _____

2. Date of Hire _____ 3. DOB _____

4. Home Address _____

5. Sex M ___ F ___ 6. SS# _____

7. Group Name _____ MIT Location ID _____

Group Address _____

8. Type of Membership (Check One)

Member Only Member/Spouse
 Member/Children Family

9. Spouse for whom coverage is desired (if necessary):

Name _____ Sex _____ Spouse SS# _____ Spouse DOB _____

Name & Address of Spouse's Employer: _____

10. List all dependent children for whom coverage is desired (if necessary)

Name	Sex	SS#	DOB
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

11. Request for Coverages

This coverage has been offered to me and careful consideration of the benefits, I have decided to:

REQUEST COVERAGE for which I am or may become eligible under the group policies issued by the Member's Insurance Trust. I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required I authorize my employer to deduct premiums from my salary.

NOT ENROLL MYSELF in the program.

NOT ENROLL MY DEPENDENTS in the program.

The insurance requested on this enrollment form will not be effective until approved by the Member's Insurance Trust, and the initial premium is paid.

Signed this _____ day of _____. Employee Signature _____ Date: _____