GEORGIA GUARD INSURANCE TRUST-DENTAL PROGRAM
P. O. BOX 889~MABLETON, GA 30126
TEL 770-739-9651 FAX 770-745-0673
TOLL-FREE: 1-800-229-1053 EMAIL: SDANIELL@GGIT.ORG

FORTIS

MUST RETURN WITH INITIAL QUARTERLY PREMIUM TO GEORGIA GUARD TRUST FOR CHOSEN PLAN

FORTIS DENTAL COVERAGE ENROLLMENT FORM

Effective Date / /	Last Name	First Name	Middle Initial	M F	Choose One: Prepaid (DentiCare) *see below	Insured: BASIC	Insured: ADVANCED
Social Security Number - -	Address				Dental Facility Number (FAC#) If you checked Prepaid coverage, write the FAC# of the dentist you choose in the space below.		
Date of Birth / /	City	State	Zip				
Home Phone ( )	Group: Georgia Guard Dental Plan		Div./Dep./Class		Work Phone ( )	Date of Membership / /	

LIST OF DEPENDENTS TO BE COVERED:

First Name	Middle Initial	Last Name (if different)	Relationship	Sex	Date of Birth
Spouse:					/ /
Children:					/ /
					/ /
					/ /
					/ /

If the address of any child is different than the member's address, please show that child's name and address below.
If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance. Please read the following and sign below.

If you selected the DentiCare Plan:
I understand that the Dental Plan is a non-refundable one (1) year program. I also understand that a full description of services will be provided in the Certificate of Benefits, and that the dentist I select may or may not perform all of the services listed on the Copayment Schedule. I authorize the dentist, who has rendered service to me or members of my family, to make available to DentiCare my dental records, photocopies or information regarding such services to the extent permitted by law.

If you selected the Fortis Freedom Plans:
I hereby apply as indicated herein for the insurance for which I am not now insured and for which I am or may become eligible under the terms of Fortis Insurance Company's group policy or policies (including any future amendments) applying to, or requested to apply to, the Georgia Guard Dental Plan named above. I represent that I am a member or former member of the Georgia National Guard.

Member's Signature: _____ Date: ____/____/____

PAYMENT OPTIONS: (CHOOSE ONE)

1. CHECK OR MONEY ORDER CHECK #_____ CHECK AMOUNT_____

   BILLING PERIOD: ___QUARTERLY ___SEMI-ANNUAL ___ANNUAL

2. MONTHLY BANK DRAFT (ENCLOSED IS A VOIDED CHECK)

   NAME OF ACCOUNT HOLDER (PRINT)_____

   BANK NAME_____

   ADDRESS_____

   CITY/STATE/ZIP_____

   SIGNATURE_____

I authorize Georgia Guard Dental Plan to deduct my dental plan premiums from my checking or savings account. I have enclosed a voided check. This authority shall remain in force until I provide prior notification to my bank and Georgia Guard Dental Plan, in writing, of the cancellation.