Dental Application

SCMA Members' Insurance Trust
P.O. Box 11188 Columbia, SC 29211
phone (803) 798-6207 fax (803) 731-4021

Member Information *All info required for New Enrollee Applications.*

Effective Date Requested		Hire Date	If existing group, give MIT Location Number:
Last Name		First Name	Middle Initial
Gender ❑ Male ❑ Female	Birth Date: MM/DD/YYYY	Social Security Number	Type of Membership ❑ Member Only ❑ Member/Children ❑ Member/Spouse ❑ Family
Home Address		City/State/Zip	County
Member Phone Number		Member Email Address	

Group Information

Group Name	Group Address	City/State/Zip

Eligible Dependents to be Covered

Name (Last, First, MI)	**Birth Date**	**Gender**	**Social Security Number**
Spouse		❑ Male ❑ Female	
Child		❑ Male ❑ Female	
Child		❑ Male ❑ Female	
Child		❑ Male ❑ Female	
Child		❑ Male ❑ Female	

Request for Coverages

This coverage has been offered to me and after 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 SCMA Members' 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.

Acknowledgement *Signature required.*

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

Print Employee Name	Date
Employee Signature	