mail today

Enrollment Instructions

1. Complete the application and sign by the **x**. (Be sure to list all Family Members to be included.)
2. Each family member may select a dental office from the list of participating dentists and insert the dental facility number on the application.
3. Complete the authorization for deduction with full information and sign in the lower portion by the "**x**."
4. Send the complete application, authorization for deduction, and check for first month's premium to CompBenefits Insurance Center, 1320 City Center Drive, Ste 300, Carmel, IN 46032. Deductions from your account will be made in accordance with the procedures established and communicated by the Credit Union.

Completed application, with correct premiums received by Home Office by the12th of the month will become effective on the 1st of the following month.

enroll today

Make checks payable to CompBenefits

*** IMPORTANT – PLEASE INCLUDE 1st MONTH'S PREMIUM WITH THIS APPLICATION.

Premium Rates	**Monthly**
One Member	13.20
Member + 1 dependent	25.02
Member + 2 or more dependents	34.14

Rates guaranteed through 1/1/11.

HUMANA®
CompBenefits

Social Security No.	Last Name	First	MI	Date of Birth

Home Address	Home Phone ( )	Business Phone ( )

City	State	Zip Code	Sex ☐ M ☐ F

Dental Facility #	Group #24156

GTE Federal Credit Union

List all your eligible dependents if they are to be covered First Middle Last (if Different)	Dental Facility #	Sex	Birthdate
2. Spouse:		☐ M ☐ F	/ /
3. Child:		☐ M ☐ F	/ /
4. Child:		☐ M ☐ F	/ /
5. Child:		☐ M ☐ F	/ /

Effective Date

Plan Code	Group Code	Premium	Amount Paid	# of DEPS	Agent Code
C150		$	$		**0103023FL**

I wish to enroll in the Dental Plan. I understand that this is a minimum one (1) year contract and that all necessary dental services will be provided as described in the Agreement and Certificate of Benefits. I have received and understand the outline of coverage.

Applicant's Signature **X** _____ Date _____

Agent Signature _____ Date _____

Authorization for Deduction — Signature Required —

Name _____ Social Security No._____
(Last) (First) (MI)

I authorize_____
(GTE Federal Credit Union)

To make a monthly deduction of $_____ from my Account Number _____

check one: ( ) checking ( ) savings

and to remit the amount deducted to CompBenefits (CB) upon instructions from (CB). The amount of deduction indicated above is approximate and may be corrected as instructed by (CB). This authorization shall cease (a) upon my giving written cancellation notice to you; (b) automatically upon my termination as a member or depositor, as the case may be, of the above named organization; (c) automatically upon termination of my checking, savings or share account numbered above as this authorization relates to such an account or (d) upon discontinuance of the deduction and remittance arrangements between the above-named organization and (CB).

I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by (CB) and if this authorization terminates for any reason, organization is acting gratuitously and for my sole accommodation and not as an agent for (CB).

Date _____20 _____Signature **X** _____