

Plan Enrollment Form. You must return the Enrollment Form fully completed to be eligible. Each person must enroll in this dental program for a minimum of one year. Plan reserves the right to transfer patient to the nearest dentist office if anyoffice receives an insufficeint enrollment.

**Benefits Unlimited Insurance Services**  
**PO Box 3119**  
**San Rafael, CA 94912**  
**(415) 459-5019 Fax:(415) 459-2124**

Social Security No.	Last Name	First	Initial	Mo.	Day	Yr.	Male <input type="checkbox"/>	Female <input type="checkbox"/>	<b>PAYMENT CHOICE</b>		
Home Address							Birthdate <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> 1199/1187 GOV'T PAYCHECK <input type="checkbox"/> BANK AUTH PLAN <input type="checkbox"/> ANNUAL PAYMENT		
Name and Address of Employer or Organization				Job Title			<b>PLAN CHOICE</b> <input type="checkbox"/> 500 A <input type="checkbox"/> 500 B <input type="checkbox"/> 100 Money Saver <input type="checkbox"/> Plan 1		Dental Center No. (If Applicable) _____		
Telephone Number (Home) _____ (Work) _____			Date Hired								
LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW											
Last Name (if different)	First Name	Initial	Sex M F	Birthdate Mo. Day Yr.	Last Name (if different)	First Name	Initial	Sex M F	Birthdate Mo. Day Yr.		
2. Spouse					5.						
3. Child					6.						
4.					7.						
Does Spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No      With whom? _____				<b>OFFICE USE ONLY</b>			<b>GROUP #</b>		<b>EFFECTIVE DATE</b>		
If answer is "Yes" are dependents enroled under spouse's plan? <input type="checkbox"/> Yes <input type="checkbox"/> No											

I UNDERSTAND THIS CONTRACT IS FOR A MINIMUM OF TWELVE MONTHS, AND RENEWED FOR TWELVE MONTHS PERIODS THEREAFTER. PLAN REQUIRES THIRTY DAYS WRITTEN NOTIFICATION OF INTENT TO CANCEL, AND IN THE EVENT OF SEPERATION OR TERMINATION, I AGREE TO PAY THE BALANCE OF ANNUAL PREMIUMS.

  X    
 MEMBER'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



Privacy Act: The collection of this information is authorized by 39 USC 401, 1003 and 5 USC 8339. This information is used to transfer your salary or portion thereof, to financial organizations for credit to your designated account. As a routine use, the information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes; where pertinent, in a legal proceeding to which the USPS is a party or has an interest; to a government agency in order to obtain information relevant to a USPS decision concerning employment, security clearances, contracts, licenses, grants, permits, or other benefits; to a government agency at your request when relevant to its decision concerning employment, security clearances, security or suitable investigations, contracts, licenses, grants, permits or other benefits; to a congressional office at your request; to an expert, consultant, or other person under contract with the USPS to fulfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review or private relief legislation; to an independent certified public accountant during an official audit of USPS finances; to an investigator, administrative judge or complaints examiner appointed by the Equal Employment Opportunity Commission for investigation of a formal EEO complaint under 29 CFR 1613; to the Merit Systems Protection Board or Office of Special Counsel for proceedings or investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to agencies having taxing authority for taxing purposes; to financial organizations receiving allotments; to State Employment Security Agencies to process unemployment compensation claims; to a Federal or state agency providing parent locator service or to other authorized persons as defined by Pub. L. 93-647; to the National Association of Postal Supervisors that relates to postal supervisors; to the Office of Personnel Management, Social Security Administration, Veterans Administration, Office of Workers' Compensation Programs, health insurance carriers, or plans, or other program management agencies or retirement systems for use in determining a claim for benefits; and to OPM for its active employees/annuitant data systems used to analyze Federal Retirement and insurance costs. Completion of this form is voluntary; however, if this information is not provided, your desires may not be met.

**Part I - (Initiated by Employee)**

1. Employee Name (As Shown on Check)		2. Social Security Number							
3. Home Address (No. and Street, Apt, City, State, Zip+4)		4a. Where Employed (City, State, Zip+4)							
Employee Express Login ID	Employee Express Password	4b. Finance Number							
		<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>							

**Complete Applicable Item(s) Below**

5a. Administration Section	
5b. ESTABLISH an ALLOTMENT in the Amount of: \$	5c. CHANGE My PRESENT ALLOTMENT FROM: \$ TO: \$
5d. CANCEL my ALLOTMENT in the Amount of:	5e. Check (✓) This Item if You Have More Than One Allotment to a Financial Organization <input type="checkbox"/>

I certify that I am entitled to the payment identified above, and that I have read and understand the information printed above. In signing this form, I authorize my payment to be sent to the financial organization named below to be deposited to the designated account.

6a. Employee (Signature) X	6b. Date Signed	6b. Effective Date <sup>1</sup> <b>ASAP</b>
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**Part II - (Completed by Financial Organization, Return Original and Copy to Employee)**

**Financial Organization Certification**

I confirm the identity of the above signed named payee(s) and the account number in title. As representative of the below named financial organization, I certify that the financial organization agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210. Pursuant to Treasury Department regulations, multiple deposits will not be made to a single common account, except for those accounts (such as husband and wife) in which employees name(s) appear in the title.

7a. Financial Organization (Name, No. and Street, City, State, ZIP + 4)  <b>CHASE MANHATTAN BANK, N.A. 1 CHASE MANHATTAN PLAZA NEW YORK, N.Y. 10081</b>	7b. Financial Organization Routing Number Check Digit <sup>2</sup> <table border="1"> <tr> <td>0</td><td>2</td><td>1</td><td>0</td> <td>0</td><td>0</td><td>0</td><td>2</td> <td>1</td> </tr> </table>	0	2	1	0	0	0	0	2	1									
0	2	1	0	0	0	0	2	1											
	7c. Employee's Account Number to Be Credited (Up to 17 positions) <table border="1"> <tr> <td>B</td><td>U</td><td>I</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	B	U	I															
B	U	I																	
	7d. Type of Account <input checked="" type="checkbox"/> Savings <input type="checkbox"/> Checking																		

**Authorized By**

8a. Name (Print or Type) <b>ALLEN J. RUSKIN</b>	8a. Title <b>VICE PRESIDENT</b>
8c. Signature 	8d. Date Signed <b>JAN 1, 2005</b>

1 Request must be received at DDE site no later than Wednesday of the week in which the pay period ends in order to be effective for a particular pay period. Later receipts will be processed the following pay period.  
2 Financial organizations must furnish their routing transit number (the number assigned by Rand McNally). This is an eight digit number plus a single digit. It is IMPORTANT that this number be accurate, as disbursements will be made according to this routing number

**NOTE: The Employee must return in the original to the Personnel Office for processing.**