DENTAL ENROLLMENT/CHANGE FORM

Please print or type clearly and complete all applicable information.

☐ **ENROLLMENT** ☐ **CHANGE** ☐ **DECLINE COVERAGE** Effective Date (For office use only) _____/_____/__

Employer:_____

Your Name: _____ S S # _____-_____-_____ Occupation:_____

Your Mailing Address: _____
(Street Name and Number or PO Box) (City) (State) (Zip)

Dental Plan # ____1 ____2 ____3 ____4 **Date of Hire**: _____ Telephone: Home ( ) ____-_____ Work ( ) ____-_____

Email Address:_____

List Eligible Dependent(s):**If you or any dependents have other dental insurance as primary coverage those with other coverage will not be eligible for benefits under the MSMA plans**

	Last Name, First	**Gender**		**Date of Birth**	**Social Security Number**	**Other Dental Coverage**
		M	**F**			**Yes or No**
Employee						
Spouse						
Partner (D.P. affidavit required)						
Child						
Child						
Child						

Request For Change:

Termination of Coverage for: ____ Self ___ Termination of employment
____ Spouse____ Partner ____Divorce
____ Child(ren)

Name Change To: _____
New Address: _____

Reason For Addition:

(List name, Social Security number and date of birth above.)

____ Marriage

____ Child Birth/Adoption

____ Loss of coverage

____Open Enrollment

Employee Signature: _____ Date Signed: _____

Employer Signature: _____ Date Signed: _____

***Fraud Statement**: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime.*