



METLIFE DENTAL PPO
ENROLLMENT/CHANGE /WAIVER FORM

Employers Name: \_\_\_\_\_ Group # \_\_\_\_\_

PLEASE PRINT ALL REQUESTED INFORMATION

1. TO ENROLL (Complete Section 1 and sign below)

Employee's Name: \_\_\_\_\_
(Last, First, MI)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Cobra - Termination Date \_\_\_\_\_
(Mo/Day/Yr)

Division \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Full Time Hire \_\_\_\_\_
(Mo/Day/Yr)

Male Female Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: Single Married Widowed Divorced

Electing Coverage for: Myself Spouse Child(ren)

If Declining coverage for yourself or dependents, complete section 3 also.

DEPENDENT COVERAGE INFORMATION (List all Eligible Dependents to be added or deleted)

Table with 5 columns: Print Full Legal Name (Last, First, MI), Date of Birth (mo day yr), ADD, DROP, RELATIONSHIP. Rows 1, 2, 3.

2. TO CHANGE NAME OR ADD/DROP DEPENDENT COVERAGE (Complete Sections 1 & 2 and sign below)

New Name \_\_\_\_\_ Old Name \_\_\_\_\_

If Due To Marriage, what is the DATE OF MARRIAGE? \_\_\_\_\_

If Due to Birth/Adoption of a child, what is the Date of Event? \_\_\_\_\_

If Due to Loss of Coverage, Date and Reason \_\_\_\_\_ (Proof Required)

Other, the Date of Event and Please Explain \_\_\_\_\_

Drop Dependent Coverage

Drop Coverage on: Spouse Child(ren) Give reason below

Due to Divorce - Date \_\_\_\_\_ Due to Death -Date \_\_\_\_\_

Other Dental Coverage elsewhere No longer student or over age

Due to Annual Election Period

3. TO WAIVE COVERAGE (Complete Section 3 and sign below)

Declining coverage for: Myself Spouse Child(ren)

Important! If declining coverage on yourself or dependents please complete one of the reasons below and sign at the bottom:
I have been given the opportunity to apply for this dental coverage offered by my employer and have decided not to accept this offer for myself or my dependents because:

I have coverage elsewhere. Provide name of insurance company: \_\_\_\_\_

Other. Reason: \_\_\_\_\_

Should I desire to apply for coverage at a later date, I will be enrolled with limitations unless I can provide satisfactory proof of prior coverage approved by the insurance carrier, the benefits will be issued standard.

If electing coverage provided by my employer, I authorize deductions from my earnings of the required contributions, if any, toward the cost of this insurance. Authorization is only necessary if employee contributions are required.

PLEASE SIGN (EMPLOYEE SIGNATURE)

Employee Signature

Date

Print Name: \_\_\_\_\_