

MetLife® \$1500/\$2000 Annual Maximum Plan
(Depending on union)

ENROLLMENT FOR GROUP DENTAL COVERAGE

TO BE COMPLETED BY EMPLOYER

Group Name: SIMSBURY PUBLIC SCHOOLS

Group Number: 1656128

Effective Date of Insurance	Cancellation Date of Insurance
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THE FOLLOWING SECTION TO BE COMPLETED BY EMPLOYEE

Please **print clearly** and be sure to sign and date this form. Return your completed form to Simsbury Public Schools Payroll / Benefits office.

Emp Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street, City, State, Zip)

Social Security Number: _____ **Date of Birth:** _____ **Title/Contract Name:** _____
(UA, SFEP, SEA, NAGE, SSASA, CAFÉ, NURSE, etc.)

Work Status: Active Retired COBRA **Date of Employment:** _____

Sex: Male Female **Marital Status:** Single Married Divorced Widowed

I received and read a copy of my employer's current announcement of the group plan.

I want to be covered under the group plan for which I am or may become eligible.

I want **personal coverage only**.

I want **personal and dependent coverage**.

My Dependent Coverage is for: Spouse Spouse and Child (ren) Child (ren)Only

Spouse's Name: _____ **Date of Birth:** _____ **Gender:** M/F

Name of Child(ren): _____ **Date of Birth:** _____ **Gender:** M/F

_____ **Date of Birth:** _____ **Gender:** M/F

_____ **Date of Birth:** _____ **Gender:** M/F

_____ **Date of Birth:** _____ **Gender:** M/F

▪ I authorize my employer to deduct from my pay any required contributions to the cost of this coverage.

I do not want to be covered for the group dental benefits for which I am eligible.

I certify that the information supplied above is true and that I am actively at work on the date of enrollment.

⇒ **Signed (Employee)** _____ **Date:** _____