MetLife® $1500 Annual Maximum Plan

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**

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.

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

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

Social Security Number: _____ **Date of Birth:** _____

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:** _____

Name of Child(ren): _____ **Date of Birth:** _____

_____ **Date of Birth:** _____

_____ **Date of Birth:** _____

_____ **Date of Birth**: _____

- **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:** _____