EDT
Employers Dental Trust®

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)

Print Full Legal Name (Last, First, MI)	Date of Birth (mo day yr)	ADD	DROP	RELATIONSHIP (Spouse, Son Daughter)
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)

_____ Print Name: _____
Employee Signature Date