

DENTAL ENROLLMENT/CHANGE FORM
 Please print or type clearly and complete all applicable information.



ENROLLMENT CHANGE DECLINE COVERAGE

Effective Date (For office use only) ___/___/___

Employee Name: _____ SSN: _____ - _____ - _____ Occupation: _____

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

Dental Plan: A (w/ortho) B (w/out ortho) Date of Hire: _____ Telephone: Home () _____ - _____ Work () _____ - _____

E-mail Address: _____

Eligible Dependent(s): *If you or any dependents have other dental insurance as primary coverage, no additional coverage will be eligible under the MSMA plans.

	Last Name, First Name	Gender		Date of Birth (required)	Social Security Number (required)	Do you have other Dental Coverage*	Are Adding or Terminating Coverage?
		M	F			Yes or No	Add or Term
Employee							
Legal Spouse							
Partner <small>Domestic Partnership affidavit required*</small>							
Child							
Child							
Child							
Child							

Termination of Coverage for: (Please list names above.)

_____ Self _____ Spouse _____ Domestic Partner _____ Child(ren)

Reason: _____ Divorce _____ Other Coverage

Reason for Addition:

Date of Qualifying Event: _____

_____ Marriage _____ Child Birth/Adoption

_____ Loss of coverage

_____ Open Enrollment (effective 7/01)

Employee 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.



Coordination of Benefits (COB)

This information will be used to distinguish the order that two or more insurance companies will pay benefits for the same claim. **If you or a dependent has other coverage that will be considered the primary payer for benefit, that individual will not be eligible for additional benefits under the MSMA plan.** Please complete this form in its entirety and return to either MSMA or Patient Advocates to avoid delay in claim processing. It is only requested upon initial enrollment. If you have changes in other dental insurance you are responsible for notifying us of this..

EMPLOYER INFORMATION

Group Number: 300 | **Plan Year:**

SECTION 1: EMPLOYEE INFORMATION

Last Name	First	Middle Initial	Date of Birth	Patient Advocates Account Number (found on your member ID card)
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In addition to this MSMA Dental Insurance plan, are you or any of your covered dependents also covered by another dental plan?

<p>NO – Please skip the rest of the questions sign at the bottom and return</p>	<p>YES – Please complete entire form, sign at the bottom and return.</p> <p style="color: red; font-weight: bold; font-size: small;">If you or a dependent has other coverage that will be considered the primary payer for benefit, that individual will not be eligible for additional benefits under the MSMA plan.</p>
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SECTION 2: OTHER DENTAL COVERAGE INFORMATION – POLICY HOLDER

Name of policy holder of other coverage	Relationship to you	Social security number	Employer	Birth date
Insurance company name and street address		City	State	ZIP code
Enrollee ID / policy number	Group number	Effective date	Cancellation date (if applicable)	
Type of Plan <input checked="" type="checkbox"/> Dental	Type of Coverage Single Two Person Family			

SECTION 3: OTHER DENTAL COVERAGE INFORMATION – DEPENDENTS

Which dependents are covered by this insurance?

Last Name	First	Middle I	Sex (M/F)	Date of Birth	Social Security Number	Relationship to you

SIGNATURE _____ **DATE** _____

If you have any questions regarding this questionnaire, please contact our Customer Service Representative at (800) 290-8559 or (207) 657-7733.
PATIENT ADVOCATES, LLC
P.O. BOX 1959
GRAY, ME 04039