MetLife

ENROLLMENT FORM FOR DENTAL BENEFITS - Dental HMO/ Managed Care

95 Enterprise, Suite 200
Aliso Viejo, CA 92656-2611
1-800-880-1800

Metropolitan Life Insurance Company

Please print clearly when completing the Enrollment Form and return it to your Benefits Coordinator. Choose a general dental office (facility number) of your choice for each eligible family member from the Directory of Participating Dentists. Failure to do so may result in delays in receiving dental care. If your first provider facility selection is not available, We will process your second selection.

SECTION TO BE COMPLETED BY BENEFITS COORDINATOR

Name of Group/Employer (Please Print) Teachers Association of Lindenhurst	Group No. TS-5374350	Division/Sub Code	Class/Branch Code	Dept Code
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			
Original COBRA Effective Date if applicable (MM/DD/YYYY)	COBRA Termination Date if applicable (MM/DD/YYYY)			

SECTION TO BE COMPLETED BY MEMBER/EMPLOYEE

Name (First, Middle, Last)	Social Security No. - -	☐Male ☐Female	☐Single ☐Married
Address (Street, City, State, Zip Code)		Date of Birth (Mo./Day/Yr.)	
☐Employee ☐Retired	Job Title:	Hours Worked Per Week:	
☐New Enrollment ☐Change in Enrollment ☐COBRA Continuation If due to a Qualifying Event, enter date (MM/DD/YYY)			
E-mail Address	Phone No. (include area code)		

SELECT A SELECTED GENERAL DENTAL OFFICE: MUST BE COMPLETED TO ENROLL IN PLAN:

Failure to select a Selected General Dental Office may result in delays in receiving dental benefits. If your first facility selection is not available, We will process your second selection. Facility numbers are found next to each Selected General Dental Office's name in the Directory of Participating Dentists.	**Facility Number - 1st Choice:**
	Facility Number - 2nd Choice:

COVERAGE REQUEST DATA:

I have received and read a copy of the group/employer's current announcement of the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below.

I request the following coverage:

Member/Employee Coverage
☐Dental

Spouse/Domestic Partner Coverage
☐Dental

Dependent Child Coverage
☐Dental

If applying for Dependent coverage (Spouse/Domestic Partner and Child), complete section below:

Choose a Selected General Dental Office (facility number) of your choice for each eligible family member from the Directory of Participating Dentists.

Number of Dependents (including Spouse/Domestic Partner):

	Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Sex (M/F)	Facility 1st	Facility 2nd
Spouse /Domestic Partner:					
Child(ren):					

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her eligibility.

For Changes Requested After Initial Enrollment Period Expires. I understand that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

For Payroll Deduction Authorization By the Member/Employee. If this group coverage is provided through my employer, I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Primary language: _____ **Please note any communication impairment**: _____

Authorization to release dental records. I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all dental records which pertain to me or any member of my family, maintained by my chosen Selected General Dentist and/or Specialty Care Dentist, to MetLife and/or any designated agent or representative for the purposes of dental treatment, care and for MetLife's quality assessment and utilization reviews, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

Fraud Warning. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature(s): The Member/Employee must sign in all cases. Each person signing below acknowledges that he or she has read and understands the statements and declarations made in this enrollment form.

_____	_____	_____
Member/Employee Signature	Print Name	Date (Mo./Day/Yr.)