DENTAL ENROLLMENT/CHANGE FORM

Please print or type clearly and complete all applicable information.

☐ **ENROLLMENT** ☐ **CHANGE** ☐ **DECLINE COVERAGE** Effective Date (For office use only) ____/____/______

Employer:____

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	Social Security Number	Other Dental Coverage*	Indicate Adding or Terminating
		M	F			Yes or No	
Employee							
Legal Spouse							
Partner (D.P. affidavit required)							
Child							
Child							
Child							

Request for Change

Termination of Coverage for: ______Self _____ Spouse _____Partner _____Child(ren)

______Divorce ______Termination of employment

Name Change To: ____

New Address: ____

Reason for Addition:

Date of Qualifying Event: ____________________

_______Marriage

_______Child Birth/Adoption

_______Loss of coverage

_______Open Enrollment

Employee Signature: ____ Date Signed: _________________

Employer Signature: ____ Date Signed: __________________

Decline of Coverage are for Employer Files only

***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)

In addition to this MSMA Dental Insurance plan, are you or any of your covered dependents also covered by another dental plan?

NO – Please skip the rest of the questions sign at the bottom and return	**YES** – Please complete entire form, sign at the bottom and return. **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.**

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 [X] 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