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: **BRUNSWICK SCHOOL DEPT**

Your Name: ______________________________ S S # _______-_______-_______ Occupation:______________________

Your Mailing Address: ____
(Street Name and Number or PO Box) (City) (State) (Zip)

Dental Plan # ____2 **Date of Hire**: _____________ Telephone: Home ( ) ____-_______ Work ( ) ____-______

Email Address:____

List 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	Gender		Date of Birth	Social Security Number	Other Dental Coverage
		M	F			Yes or No
Employee						
Spouse						
Partner (D.P. affidavit required)						
Child						
Child						
Child						

Request For Change:

Termination of Coverage for: _____ Self ___ Termination of employment
_____ Spouse____ Partner ____Divorce
_____ Child(ren)

Name Change To: ______________________________________
New Address: ______________________________________

Reason For Addition:

(List name, Social Security number and date of birth above.)

_____ Marriage

_____ Child Birth/Adoption

_____ Loss of coverage

_____Open Enrollment

Employee Signature: ____ Date Signed: _______________

Employer 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.*