Fill in information for just yourself. Any dependents are automatically dropped if you drop coverage.

DENTAL ENROLLMENT/CHANGE FORM

Please print or type clearly and complete all applicable information.

☐ ENROLLMENT ☒ CHANGE ☐ DECLINE COVERAGE Effective Date (For office use only) Leave blank

Employer: South Portland School Department

Your Name: _____ S.S.# _____ Occupation: _____

Fill in required personal information.

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

Dental Plan # ___1 ___2 ___3 ___4 Date of Hire: _____ Telephone: Home ( ) ____-_____ Work ( ) ____-_____

Email Address: _____

List Eligible Dependent(s): **If you or any dependents have other dental insurance as primary coverage those with other coverage will not be eligible for benefits 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: Sign. _____ Date Signed: Date. _____

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.*

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