SEA & SPESPA must choose plan B. Non-Bargaining have a choice between plan A or plan B.

Fill in required information for self, dependents / spouse/ partner if including in coverage.

DENTAL ENROLLMENT/CHANGE FORM

Please print or type clearly and complete all applicable information.

MSMA
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[X] **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 X 2 ___3 X 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

_X_ 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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Fill in personal information. The patient advocate account number can found on the back of your MSMA dental card. If you can't find your card, send in the form without the number. Please call 622-3473 to order a new card.

Answer Yes or No

If you answered 'yes' above, fill out section 2, if you answered 'no' leave it blank.

If you answered 'yes' above, fill out section 3, if you answered 'no' leave it blank.

Sign and date.

MSMA
MAINE SCHOOL MANAGEMENT ASSOCIATION

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 benefits under the MSMA plan.** Please complete this form in its entirety and return to Patient Advocates to avoid delay in claim processing.

EMPLOYER INFORMATION

Group Number: 300	**Plan Year:**

SECTION 1: EMPLOYEE INFORMATION

Last Name	First	Middle Initial	Date of Birth	Patient Advocates Account Number

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 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 coverage ☐ **Single** ☐ **Two Person** ☐ **Family**	Type of plan: ☒ Dental			

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

South Portland School Department

PREMIUM ONLY FLEXIBLE BENEFITS PLAN

ELECTION FORM AND SALARY REDUCTION AGREEMENT

I ,_____, have been informed of my right to participate in the South Portland School Department Premium Only Flexible Benefits Plan (the "Plan").

With respect to Plan benefits for the period July 1, 2019 through June 30, 2020, I hereby make the following elections, pursuant to Article IV of the Plan:

[ ] A. I have enrolled for medical benefit coverage. I elect to receive my medical coverage under the South Portland School Department Premium Only Flexible Benefits Plan. Any previous election and compensation reduction agreement under the Flexible Benefits Plan relating to the same benefits is hereby revoked. I authorize the Employer to make aggregate payroll deductions in the amount of my required contributions for the benefit option I have elected under the Flexible Benefits Plan, in equal installments.

[ ] B. I have enrolled for dental benefit coverage. I elect to receive my dental coverage under the South Portland School Department Premium Only Flexible Benefits Plan. Any previous election and compensation reduction agreement under the Flexible Benefits Plan relating to the same benefits is hereby revoked. I authorize the Employer to make aggregate payroll deductions for the benefit option I have elected under the Flexible Benefits Plan, in equal installments.

[ ] C. I do not elect to participate in the Plan at this time and thus no payroll deductions for the above purposes shall be made.

I recognize that the above election(s) is (are) *irrevocable* for the period stated above (except as may be allowed by IRS regulations) and that I will not be entitled to receive any nonelective portion of the amount(s) specified above as cash compensation.

Dated _____ Signature _____

OFFICE USE ONLY

CIRCLE ONE:
INITIAL ELECTION NEW EMPLOYEE FAMILY STATUS CHANGE

DESCRIBE THE FAMILY STATUS CHANGE:_____
DATE OF FAMILY STATUS CHANGE:_____
DATE RECEIVED:_____
RECEIVED BY:_____

FBP
PREMELE2001.DOC

You must return your enrollment form with a salary reduction agreement as shown to the left. If you would like your dental insurance premiums removed from your pay check before taxes are removed (the most popular option) check box B. If you would like to pay taxes on the health insurance premiums being removed from your pay, select option C. Date and sign.