

**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: \_\_\_\_\_ **Fill in required personal information.** Occupation: \_\_\_\_\_

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: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ **Sign.**

Employer Signature: \_\_\_\_\_

**Reason For Addition:**

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

Marriage  
 Child Birth/Adoption  
 Loss of coverage

Open Enrollment **Changing plans**

Date Signed: \_\_\_\_\_ **Date.**

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.

Non-Bargaining ONLY have a choice between plan A or plan B.

Fill in information for yourself and any dependent(s) you would like on the plan.

Write in 'changing plans' next to Open Enrollment



### 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.

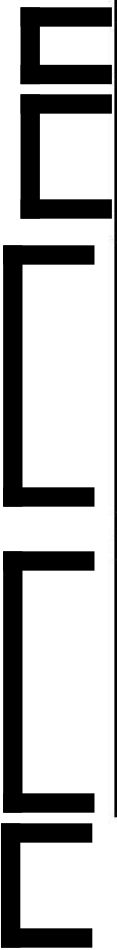
**Fill in personal information.** The patient advocate account number can found on the back of your MSMA dental card. If you can't find your card, send in the form without the number. Please call 622-3473 to order a new card.

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.



EMPLOYER INFORMATION						
Group Number: 300			Plan Year:			
SECTION 1: EMPLOYEE INFORMATION						
Last Name		First	Middle Initial	Date of Birth	Patient Advocates Account Number	
<i>In addition to this MSMA Dental Insurance plan, are you or any of your covered dependents also covered by another dental plan?</i>						
<input type="checkbox"/> NO – Please skip the rest of the questions sign at the bottom and return			<input type="checkbox"/> YES – Please complete entire form, sign at the bottom and return.			
<b>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.</b>						
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 <input type="checkbox"/> Single <input type="checkbox"/> Two Person <input type="checkbox"/> Family		Type of plan: <input checked="" type="checkbox"/> Dental				
SECTION 3: OTHER DENTAL COVERAGE INFORMATION – DEPENDENTS						
<i>Which dependents are covered by this insurance?</i>						
LastName	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