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

DENTAL ENROLLMENT/CHANGE FORM

Please print or type clearly and complete all applicable information.

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

Employer: South Portland School Department

Your Name: _____ SS# _____ 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 Changing plans

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.

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