SEA & SPESPA have plan B. Non-Bargaining have plan A or plan B.

Fill in information for any dependent(s) you would like to drop from the plan.

Mark the most appropriate selection(s) according to who you are dropping. If you select 'self' everyone on your plan will lose coverage.

DENTAL ENROLLMENT/CHANGE FORM

Please print or type clearly and complete all applicable information.

MSMA
MAINE SCHOOL MANAGEMENT ASSOCIATION

☐ 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)

Reason For Addition:

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

____ Marriage
____ Child Birth/Adoption
____ Loss of coverage
____ Open Enrollment

Name Change To: _____
New Address: _____

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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