DMBA
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SENIOR DENTAL PLAN ENROLLMENT FORM

❑ NEW ENROLLMENT ❑ MID-YEAR CHANGE ❑ OPEN ENROLLMENT

A. PERSONAL INFORMATION (REQUIRED—COMPLETE IN FULL)

Retiree name: _____ DMBA ID number: _____

Home address: _____ Phone number: _____

City: _____ State:_____ ZIP code:_____

Birth date: _____ Marital status: _____

B. DENTAL COVERAGE

❑ I want to enroll in the Senior Dental Plan. (Complete parts D and F of this form. If you don't have medical coverage with DMBA, also complete part C.)

❑ I do not want to enroll in the Senior Dental Plan. (Complete part E.)

C. COVERAGE LEVEL AND DEPENDENT INFORMATION

If you have medical coverage with DMBA, you don't need to complete this section. Your level of dental coverage will be the same as your level of medical coverage. If you're enrolling in the Senior Dental Plan only, choose your coverage level below:

❑ For myself

❑ For myself and one dependent

❑ For myself and two or more dependents

List your spouse and all legal dependents from oldest to youngest. I**f you omit any dependents or don't add new dependents, they will not be covered.**

DEPENDENT NAME (FIRST, MIDDLE, LAST)	BIRTH DATE (MM/DD/YYYY)	RELATIONSHIP TO RETIREE	SEX	SOCIAL SECURITY NUMBER
		Spouse		

YOU MUST COMPLETE THE BACK OF THIS FORM!

D. AUTHORIZATION

I hereby apply for the coverage specified in this form. I understand the benefits of this plan, including the various options and conditions given above. Furthermore, I authorize any dentist, clinic, any other provider of dental care, insurance company, or my former employer to disclose to DMBA or its representatives all information and records about any condition or treatment of me, my spouse, or my dependents relating to diagnosis, treatment, history, and condition.

I authorize the deduction of premiums from my Master Retirement Plan benefit. If my Master Retirement Plan benefit is not large enough to cover the premium, I understand I will be billed separately for this coverage and agree to pay the premium to DMBA.

Printed name: _____ DMBA ID number:_____

Retiree signature: _____ Date: _____

E. WAIVER OF BENEFIT (SIGN ONLY IF YOU REJECT BENEFITS)

I understand the benefits of the Senior Dental Plan. I choose not to participate in this plan for myself and/or my dependents and hereby waive such coverage. I also understand that in waiving this coverage, I am not eligible to enroll at a later date.

Printed name: _____ DMBA ID number:_____

Retiree signature: _____ Date: _____

F. OTHER DENTAL COVERAGE

Are you covered by another dental plan? ❑ Yes ❑ No

If yes, provide the following information:

Carrier name:_____

Carrier telephone number:_____

Policy holder:_____

Policy number:_____