DENTAL ENROLLMENT/CHANGE FORM

(Please print or type)

☐ **ENROLLMENT** ☐ **CHANGE** Effective Date of Coverage or Change: _____/_____/_____

School: Westbrook School Department MSAD # _____ School Union # _____ CDS _____

Employee's Name: _____ S S # _____-_____-_____ Occupation:_____

Address: _____
(Street) (City) (State) (Zip)

Dental Plan # ____1 __X__2 ____3 ____4 Date of Hire: _____ Telephone: Home ( ) ____-_____ Work ( ) ____-_____

List Eligible Dependent(s):

	Last Name, First	Sex M	Sex F	Date of Birth	Social Security Number
Employee		☐	☐		
Spouse		☐	☐		
Partner		☐	☐		
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
☐ I hereby decline dental coverage
☐ Open Enrollment

Employee Signature: _____ Date Signed: _____

Spouse/Partner Signature: _____ Dependent Signature: (if age 18 or over) _____

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.*