

ACTIVATION FORM FOR THE DENTAL INSURANCE PLAN

Complete this form and return to:
VOLUNTARY BENEFITS PLAN®
P.O. Box 12009
Cheshire, CT 06410



Underwritten by:
MetLife
 Metropolitan Life Insurance Company
 New York, New York

MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

Member's Name: _____ Social Security Number: _____
Last Name First Middle Initial

Home Address: _____
Street City State Zip Code

Phone: (____) _____ E-mail Address: _____ Local: _____

Date of Birth: ____/____/____ Sex: Male Female Marital Status: Married Divorced Single Widowed
(MM/DD/YYYY)

Employment Status: Active PSE Retired Associate

COVERAGE

(Refer to the brochure or your certificate for eligibility, options and coverage descriptions.)

I HEREBY ENROLL IN THE FOLLOWING GROUP DENTAL INSURANCE PLAN: *(Choose one)*

PLAN: WITHOUT ORTHODONTIC COVERAGE WITH ORTHODONTIC COVERAGE

INDICATE COVERAGE DESIRED: *(Choose one)*

Member Only Member & Spouse/Domestic Partner Member & Child Member & Spouse/Domestic Partner & Child(ren)

If **DEPENDENT** coverage is requested, list eligible dependents

(Lawful spouse and unmarried dependent children under age 19, 25 if a full-time student.) (Subject to state variations.)

SPOUSE'S/DOMESTIC PARTNER'S FULL NAME (Last, First, Mid. Init.)			Social Security Number	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
1. (Child Name)	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	4. (Child Name)	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
2. (Child Name)	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	5. (Child Name)	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
3. (Child Name)	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	6. (Child Name)	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female

NOTE: *If both parents are members, child(ren) can only be covered by one parent.*

I hereby enroll for and authorize the necessary salary deductions (for Active & PSE members) or Quarterly Direct Bill (For Retiree & Associate members) for the premium to pay for insurance in the APWU Health Plan's Dental Plan underwritten by MetLife Insurance Company. I further agree to participate in the Dental Plan for a minimum of one year. I understand that coverage applied for shall become effective on the first day of the period my first premium is received following the date of approval.

I have read and understand the conditions and exclusions of the program.

Important Notice – 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 may be a crime. (Fraud provisions vary by state.)

Member Signature X *(Sign in ink)* _____ /____ /____
Date

NOTE: *If you have made corrections or strikeouts on this enrollment form, the Member MUST initial them.*

