MetLife Dental Enrollment/Change Form

HR-BEN-061

Section 1 - Information and Instructions

Complete this form to enroll or change employee and/or dependent coverage in the MetLife Dental Plan.

IMPORTANT:

- **ALL** sections of this form **MUST** be completed.
- **ALL** required supporting documentation **MUST** be submitted with the completed enrollment/change form.

Please submit a completed, legible, and signed copy of the form via email to bscservice@mtabsc.org **OR** via fax to 212-852-8700.

If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123, 8:30 AM – 5:00 PM, Monday to Friday **OR** at bscservice@mtabsc.org

Section 2 - Employee Information

Print Name	Last		First		M.I.	Suffix	BSC ID#
Agency/Dept. (check one)	☐ BSC	☐ B&T	☐ C&D	☐ HQ	☐ Police		Department
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT		
					☐ MABSTOA		
Street Address							
City					State		Zip Code
Phone (H)			Phone (W)				Email
Managerial/Non-Rep ☐ No ☐ Yes			Agreement (Represented) ☐ No ☐ Yes (If Yes, please indicate your Union Code):				

Section 3 - Coverage Type

☐ New Enrollment ☐ Reinstatement ☐ Waive Coverage

Change of Status:

☐ Add Dependent/Domestic Partner ☐ Delete Dependent/Domestic Partner

Section 4 - Dependent Data Information

Please list all of your eligible dependent(s) you would like to enroll in MetLife Dental coverage:

Name (First, M.I., Last)	Relationship to Employee	Date of Birth	Social Security#

Section 5 - Authorization

My signature and date on this form hereby certifies that to the best of my knowledge, the above information is true, correct, and current. I also certify that dependent children from age 19 to 26 that I have enrolled in coverage are not eligible for another employer-sponsored coverage.

I understand that if my coverage is waived, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date.

Employee Signature	Date