DENTAL ENROLLMENT / CHANGE FORM

PLEASE TYPE OR PRINT LEGIBLY - IN BLUE OR BLACK INK ONLY

PLAN YEAR IS FEBRUARY 1ST THROUGH JANUARY 31ST

1. SUBSCRIBER INFORMATION - To be completed by Retiree

LAST NAME (SUBSCRIBER)	FIRST NAME, Middle Initial	SOCIAL SECURITY NUMBER	GENDER (M/F)	DOB (MM-DD-YYYY)

MAILING ADDRESS	CITY, STATE, ZIP	E-MAIL AND PHONE #

Please mail form to: MAR, 280 Maine Avenue, Farmingdale, Maine 04344

or please e-mail form to: mar@maineretirees.org **Contact MAR: (800) 535-6555**

2. REASON FOR ENROLLMENT / CHANGE

EFFECTIVE DATE (MM/DD/YYYY)	EXACT DATE OF STATUS CHANGE (If different from Effective Date)

ADD:		DELETE:	
Annual/Open Enrollment		Annual/Open Enrollment	
COBRA Due to end		Employment change	
Marriage		Divorce	
Adoption/Birth		Deceased	
Employment change		No longer Dependent (IRS)	

MISCELLANEOUS CHANGE/DELETE: (Explain)

There are two dental plan options (please check one)

Coverage Level	$750 Plan	$1,250 Plan	Coverage Level	$750 Plan	$1,250 Plan
Single Coverage			Retiree & Children		
Retiree & Spouse			Retiree & Family		
Retiree & Child					

3. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by a change listed above.

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Relationship to Subscriber	Dental (Yes / No)

4. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Are you currently covered under a Dental Plan with Crown, Bridge and Denture Coverage? (Y/N)

Will you, your spouse or any dependent be covered under any other group Dental plan while this policy is in effect? (Y/N)

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by MAR. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. **By signing below I hereby accept coverage.**

SIGNATURE **DATE**

Please retain a copy for your records