DENTAL ENROLLMENT / CHANGE FORM

Maine Association of Retirees

PLEASE TYPE OR PRINT LEGIBLY - IN BLUE OR BLACK INK ONLY
PLAN YEAR IS JANUARY 1ST THROUGH DECEMBER 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 #

2. REASON FOR ENROLLMENT / CHANGE

EFFECTIVE DATE (MM/DD/YYYY)

EXACT DATE OF STATUS CHANGE (IF DIFFERENT FROM EFFECTIVE DATE)

ADD:

- ☐ Annual/Open Enrollment
- ☐ COBRA Due to end
- ☐ Marriage
- ☐ Adoption/Birth
- ☐ Employment change

DELETE:

- ☐ Annual/Open Enrollment
- ☐ Employment change
- ☐ Divorce
- ☐ Deceased
- ☐ No longer Dependent (IRS)

MISCELLANEOUS CHANGE/DELETE: (EXPLAIN)

There are three dental plan options (please check one)

Coverage Level	$750 Plan	$1,250 Plan	$2,000 Plan
Single Coverage	☐	☐	☐
Retiree & Spouse	☐	☐	☐
Retiree & Child	☐	☐	☐
Retiree & Children	☐	☐	☐
Retiree & Family	☐	☐	☐

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

Contact MAR: (800) 535-6555
Please mail form to: MAR, 157 Capitol St., Suite 4, Augusta, ME 04330 or please e-mail form to: mar@maineretirees.org

Please retain a copy for your records