

Dental Insurance Enrollment Form
Metropolitan Life Insurance Company



EMPLOYER INFORMATION			
EMPLOYER: Grand Forks County		GROUP #: 05599923	
Reason for completing this form:	<input type="checkbox"/> New Subscriber	<input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> Add a Family Member
	<input type="checkbox"/> Change Address	<input type="checkbox"/> Change Name	<input type="checkbox"/> Remove a Family Member
			Effective Date:

EMPLOYEE INFORMATION			
EMPLOYEE NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY #	SEX
MAILING ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	DATE OF EMPLOYMENT	DEPARTMENT
MARITAL STATUS			
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			

COVERAGE INFORMATION	Indicate your desired level of coverage.
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + 1 dependent <input type="checkbox"/> Employee + 2 or more dependents	<i>I decline dental coverage for:</i> <input type="checkbox"/> Spouse <input type="checkbox"/> Children

DEPENDENT INFORMATION	Please list the dependent family members you wish to insure.		
	NAME	DATE OF BIRTH	RELATIONSHIP
Spouse			
Child 1			
Child 2			
Child 3			
Child 4			
Child 5			
Child 6			
Child 7			

I hereby apply to MetLife for Group Dental Insurance as presented to me and authorize my employer to make any necessary deduction from my salary to pay the premium when my insurance becomes effective.

Employee Signature _____ Date _____