



# DENTAL ENROLLMENT FORM

**Human Resources - Benefits**  
One Park Place South, 3<sup>rd</sup> Floor

**Mailing Address:**  
P. O. Box 3982  
Atlanta, GA 30302-3982  
Office Phone: (404) 413-3330  
Office Fax: (404) 413-3335

LAST NAME, First, Middle			Panther #		<b>HR Use Only</b>
Home Address		Marital Status	Email address		HR Empl ID
City	County	State	ZIP	Campus Phone #	Date of Hire
					Effective Date

Plan	Employee	Employee + Spouse	Employee + 1 Child	Family
<b>BOARD OF REGENTS</b>				
<b>METLIFE</b>				

Last name, First, MI	Date of Birth mm/dd/yy	Sex	Dependents age 19-26 Full Time Student or Disabled?
Employee		M    F	N/A
Spouse		M    F	N/A
Child		M    F	Yes    No
Child		M    F	Yes    No
Child		M    F	Yes    No

**Eligible dependents** for healthcare coverage are defined as: Spouse through legal marriage (unless legally separated); unmarried child through age 18; unmarried child ages 19-26 if enrolled as a fulltime student in an accredited school (documentation required); stepchild or other child for whom you have assumed a legal obligation (documentation required). A marriage license, birth certificate, or other document establishing a dependent relationship is required for any dependent whose last name differs from yours. **APPROPRIATE DOCUMENTS MUST BE SUBMITTED IN ORDER FOR COVERAGE TO BE ACTIVATED. If you are changing healthcare plans please attach the required documentation to add your spouse and dependents even if you have previously submitted documentation, i.e. marriage license FTS certification, birth certificates.**

**ENROLLMENT AGREEMENT**

I hereby apply for membership for myself and the eligible dependents listed above. The information I have provided is true and complete to the best of my knowledge. I understand that my coverage and benefits may be affected by failure to provide complete and accurate information. I also authorize my healthcare providers to exchange information regarding any person included under my coverage and to provide such information to other healthcare providers and to insurers as necessary for the provision of care, the administration of the service agreement and the settlement of claims. I also consent to the assignment of benefits to the Health Plan which I may have in circumstances where a party other than my Health Plan may be responsible for all or a portion of, the cost of services provided to me. I agree to pay the premium amounts applicable for the contract under which I am covered. I understand and agree that non-payment or checks returned for insufficient funds for any period in excess of 30 days will result in the permanent cancellation of my coverage.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

09/07

	HR USE
Paycode: _____	
Payroll Process Date: _____	
By: _____	
Date: _____	