Momentum Insurance Plans, Inc.
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Benefit Enrollment/Change Form
Dental

Employer Use Only

Group #: **Effective Date:**

1. EMPLOYEE INFORMATION

☐ **Initial Application** ☐ **Change to existing enrollment** ☐ **Cancellation** ☐ **No Change**

Last Name	First Name	MI	Social Security #	Gender ☐ Male ☐ Female

Home Address (Street, City, State, Zip)

Home Phone (xxx-xxx-xxxx)	Work Phone (xxx-xxx-xxxx)	Marital Status	Date of Birth	Date of Hire

E-mail Address

Employer Name and Location (City & State)

2. TYPE OF DENTAL COVERAGE SELECTED

Standard Plan: ☐ Employee ☐ Employee+1 ☐ Family | **Plus Plan**: ☐ Employee ☐ Employee+1 ☐ Family

3. DEPENDENT INFORMATION – List all eligible family members to be covered

Last Name	First Name	MI	Dependent Relationship (Spouse, son, daughter, stepson, etc)	Does dependent meet IRS qualifications as tax dependent?	Social Security #	Date of Birth	For Changes Only
				☐ Yes ☐ No			☐ Add ☐ Delete
				☐ Yes ☐ No			☐ Add ☐ Delete
				☐ Yes ☐ No			☐ Add ☐ Delete
				☐ Yes ☐ No			☐ Add ☐ Delete
				☐ Yes ☐ No			☐ Add ☐ Delete
				☐ Yes ☐ No			☐ Add ☐ Delete

4. COORDINATION OF BENEFITS

Are you, your spouse, or other dependent(s) covered by any other dental plan that will remain in effect? ☐ Yes ☐ No
If yes, which family member(s) will be covered? ☐ You ☐ Your Spouse ☐ Dependent(s)
Please list all other dental coverage below:

Name of Insured:	Name of Person(s) Policy Issued to:	Policy #:

Name of Plan/Insurance Company:	Address:

4. COORDINATION OF BENEFITS (continued)

Name of Insured:	Name of Person(s) Policy Issued to:	Policy #:
Name of Plan/Insurance Company:	Address:	

Name of Insured:	Name of Person(s) Policy Issued to:	Policy #:
Name of Plan/Insurance Company:	Address:	

Name of Insured:	Name of Person(s) Policy Issued to:	Policy #:
Name of Plan/Insurance Company:	Address:	

5. REASON FOR CHANGE (if applicable)

☐ Marriage
☐ Divorce
☐ Birth/Adoption
☐ Change in dependent eligibility status
☐ Gain of other Coverage
☐ Loss of other Coverage
☐ Death
☐ Address Change
☐ Name Change - Former Name: _____
☐ Other _____

Date of Change: _____/_____/_____

Employees making changes to benefit coverage due to a change in family or eligible employment status must attach supporting documentation for the qualifying event. All forms must be turned in to the Human Resources department within **30 calendar days** from the date of the qualifying event.

6. ACCEPTANCE OF COVERAGE (complete this section if you are accepting coverage)

☐ **YES**, I **accept** the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period or if an allowable change in status has occurred and I have notified the Human Resources department and completed the appropriate paperwork within 31 days of the qualifying event.

If you are not accepting coverage for your spouse or dependents, are they covered by another dental plan? ☐ Yes ☐ No

By signing this form, I certify that all information supplied is true to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the terms of the plan(s) in which I have enrolled and I agree to abide by the terms and conditions provided in the plan(s).

Employee Signature	**Date**

7. WAIVER OF COVERAGE (complete this section only if you are waiving coverage)

☐ **NO**, I **decline** the opportunity to enroll in my employer's group insurance plan. I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the terms and conditions of the Group Master Contract, which may require additional limitations and waiting periods. I also understand that Momentum Insurance Plans, Inc. reserves the right to reject such an application.

Please check one:
☐ I have coverage through my spouse
☐ I have other dental coverage
☐ I do not have other dental coverage

Employee Signature	**Date**