TOWN OF EMERALD ISLE
MET LIFE DENTAL

EMPLOYEE INFORMATION			
Company Name: **Town of Emerald Isle**			
Employees Last Name	First Name	Middle Initial	DOB:
Sex: Male ☐ Female ☐	Social Security Number	Home Phone	

COVERAGE INFORMATION

CANCELLATION OF COVERAGE

Check the coverage you wish to CANCEL

DENTAL

☐ Myself ☐ Dependent(s) Coverage

ADDITION OF COVERAGE

Check the coverage you wish to ADD

DENTAL

☐ Myself ☐ Dependent(s) Coverage PLAN OPTION: ☐ BASIC ☐ BUY-UP

Dependents:

First/Middle/Last	Birthdate	Sex	Relationship	Disabled*

*If dependent is disabled and over age 26, please submit proof of disability

TO BE COMPLETED BY EMPLOYEE

Employee's signature is required for all changes and terminations except termination of employment.

I agree that to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage by any underwriter or carrier. Subject to the approval of this application the benefits applied for shall become effective in accordance with the summary plan description of your employer's health care plan.

Signature of Employee: _____ Date: _____

TO BE COMPLETED BY EMPLOYER

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This section must be completed in order to be processed. *I certify the information to be complete and accurate to the best of my knowledge.* Authorized Signature:_____ Date :_____