DMBA

SENIOR DENTAL PLAN ENROLLMENT FORM

☐ New enrollment ☐ Mid-year change ☐ Open enrollment

A. PARTICIPANT INFORMATION (REQUIRED–COMPLETE IN FULL)

Retiree name:_____ DMBA ID number:_____

Primary phone:_____ Email: _____

Home address: _____ City: _____ State: _____ ZIP code: _____

Birth date: _____ Marital status:_____

B. DENTAL PLAN

☐ I want to enroll in the Senior Dental Plan. (Complete parts D and F of this form. If you don't have medical coverage with DMBA, also complete part C.)

☐ I do not want to enroll in the Senior Dental Plan. (Complete part E.)

C. COVERAGE LEVEL AND DEPENDENT INFORMATION

If you have medical coverage with DMBA, you don't need to complete this section. Your level of dental coverage will be the same as your level of medical coverage. If you're enrolling in the Senior Dental Plan only, choose your coverage level below:

☐ Myself ☐ Myself and one dependent ☐ Myself and two or more dependents

For dependent coverage, complete the following information. List your spouse and all legal dependents from oldest to youngest. **If you omit any dependents during initial enrollment, they will not be covered**.

DEPENDENT NAME (FIRST, MIDDLE INITIAL, LAST)	BIRTH DATE (MM/DD/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX	SOCIAL SECURITY NUMBER (REQUIRED)
		SPOUSE	☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	

D. AUTHORIZATION

I hereby apply for the coverage specified in this form. I understand the benefits of this plan, including the various options and conditions given above. Furthermore, I authorize any dentist, clinic, any other provider of dental care, insurance company, or my

former employer to disclose to DMBA or its representatives all information and records about any condition or treatment of me, my spouse, or my dependents relating to diagnosis, treatment, history, and condition.

I authorize the deduction of premiums from my Master Retirement Plan benefit. If my Master Retirement Plan benefit is not large enough to cover the premium, I understand I will be billed separately for this coverage and agree to pay the premium to DMBA.

Printed name: _____ DMBA ID number: _____

Signature: _____ Date: _____

E. WAIVER OF BENEFITS (SIGN *ONLY* IF YOU REJECT ALL BENEFITS)

I understand the benefits of the Senior Dental Plan. I choose not to participate in this plan for myself and/or my dependents and hereby waive such coverage. I also understand that in waiving this coverage, I am not eligible to enroll at a later date.

Printed name: _____ DMBA ID number: _____

Signature: _____ Date: _____

F. OTHER DENTAL COVERAGE

Are you or your dependents covered by any dental plan other than a DMBA plan? ☐ Yes ☐ No

If yes, provide the following information:

Carrier name: _____

Carrier address: _____

Carrier telephone number: _____

Policy holder: _____

Policy number: _____

G. COMMENTS

Please return this completed form to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530. You may also email it to enrollmenthelp@dmba.com or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or toll free at 800-777-3622.