

SENIOR DENTAL PLAN ENROLLMENT FORM

New enrollment
 Mid-year change
 Open enrollment

A. RETIREE INFORMATION (REQUIRED—COMPLETE IN FULL)

Retiree name: _____ DMBA ID number: _____
 Primary phone: _____ Email: _____
 Home address: _____ City: _____ State: _____ ZIP code: _____
 Birth date: _____ Marital status: _____

B. CHOOSING YOUR BENEFITS

- I want to enroll in the Senior Dental Plan. (Complete parts D and E 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.

RELATIONSHIP TO RETIREE	NAME (FIRST, MIDDLE INITIAL, LAST)	BIRTH DATE (MM/DD/YYYY)	SEX	SOCIAL SECURITY NUMBER (REQUIRED)
S - Legal Spouse			M F	
N - Natural or Adopted Child			M F	
SC - Stepchild			M F	
MC - Married Child			M F	
GC - Grandchild			M F	
O - Other (Specify in comments)			M F	
			M F	

D. 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:

Other insurance carrier name: _____ Carrier telephone number: _____

Carrier address: _____

Policy holder name: _____ Policy number: _____

E. RETIREE AUTHORIZATION (REQUIRED)

I wish to enroll or make changes as indicated on this form. I wish to waive or discontinue all benefits.

If waiving or discontinuing benefits, I understand the benefits of the Senior Dental Plan. I choose not to participate in this plan for myself and 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.**

If applying for benefits, by completing this enrollment application, I agree to the following:

- **PREMIUM DEDUCTION:** I hereby apply for the benefits specified and authorize the deduction of my portion of the premiums from my Master Retirement Plan benefit. If my Master Retirement Plan benefit is not large enough to cover the premium, I'll be billed individually for this coverage and agree to pay the premium to DMBA. I understand the benefits of this program, including the various options and conditions given herein.
- **INFORMATION RELEASE:** The information on this enrollment form is correct to the best of my knowledge. If I intentionally provide false information on this form, I'll be disenrolled from the plan. My signature on this application (or the signature of the person authorized to act on my behalf under the laws of the state where I reside) means I have read and understand the contents of this application. If signed by an authorized individual as described above, this signature certifies that: 1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by DMBA or by Medicare. I also 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.

If someone is signing this authorization on your behalf, documentation showing legal authority to do so (such as a power of attorney or guardianship) is required. Please attach a copy to this form before submission unless we have already received, reviewed, and approved this documentation. We cannot process your enrollment until we have the required documents on file.

I am the: Retiree Personal representative Relationship to retiree (if applicable): _____

Signature: _____ Date signed: _____

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