ACTIVATION FORM FOR **RETIREE DENTAL INSURANCE PLAN**

Complete this form and return to:
VOLUNTARY BENEFITS PLAN®
P.O. Box 12009
Cheshire, CT 06410

Voluntary Benefits Plan®
Benefits for Members of the
American Postal Workers Union

Underwritten by:
MetLife
Metropolitan Life Insurance Company
New York, New York

MEMBER INFORMATION
PLEASE PRINT IN INK OR TYPE ALL ANSWERS

Member's Name: _____ (Last Name) _____ (First) _____ (Middle Initial) Social Security Number: _____

Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Home Phone: (____) _____ E-mail Address: _____

Date of Birth: ____/____/____ (MM/DD/YYYY) Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

COVERAGE
(Refer to the brochure or your certificate for eligibility, options and coverage descriptions.)

I HEREBY ENROLL IN THE FOLLOWING GROUP RETIREE DENTAL INSURANCE PLAN: *(Choose one)*

PLAN: ☐ HIGH OPTION ☐ LOW OPTION

INDICATE COVERAGE DESIRED: *(Choose one)*

☐ Retired Member Only ☐ Member & Spouse ☐ Member & Child ☐ Member, Spouse & Child(ren)

If **DEPENDENT** coverage is requested, list eligible dependents
(Lawful spouse and unmarried dependent children under age 19, 25 if a full-time student.) (Subject to state variations.)

SPOUSE'S FULL NAME (Last, First, Mid. Init.)			Social Security Number	Date of Birth / /	☐ Male ☐ Female
1. (Child Name)	Date of Birth / /	☐ Male ☐ Female	3. (Child Name)	Date of Birth / /	☐ Male ☐ Female
2. (Child Name)	Date of Birth / /	☐ Male ☐ Female	4. (Child Name)	Date of Birth / /	☐ Male ☐ Female
5. (Child Name)	Date of Birth / /	☐ Male ☐ Female	6. (Child Name)	Date of Birth / /	☐ Male ☐ Female

OPTIONAL COVERAGE ELECTION *(Available only for eligible dependent children under age 19)*

Do you wish to add Optional Orthodontic Coverage? ☐ Yes ☐ No *(If you check YES your Plan Premium will automatically increase by 10%)*

NOTE: *If both parents are members, child(ren) can only be covered by one parent.*

PREMIUM PAYMENT INFORMATION: *(Check one)* ☐ ANNUAL ☐ QUARTERLY ☐ MONTHLY *(Monthly election requires Electronic Funds Transfer Method)*

I hereby enroll for insurance in the Voluntary Benefits Plan Dental Plan underwritten by Metropolitan Life Insurance Company, New York, New York. I further agree to participate in the Dental Plan for a minimum of one year. I understand that coverage applied for shall become effective on the first day of the period my first premium is received following the date of approval.

I have read and understand the conditions and exclusions of the program.

Important Notice – Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false Information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. (Fraud provisions vary by state.)

_____ ____/____/____
Member Signature X *(Sign in ink)* *Date*

PLEASE NOTE: You must notify the Voluntary Benefits Plan of any address change, employment or union membership status change, life status change (i.e., marriage, divorce, beneficiary or name change) or benefit changes requested. Notice must be in writing.

NOTE: *If you have made corrections or strikeouts on this enrollment form, the Member MUST initial them.*