ACTIVATION FORM FOR **DENTAL INSURANCE PLAN**

Complete this form and return to:
VOLUNTARY BENEFITS PLAN®
P.O. Box 12009
Cheshire, CT 06410
or email to vbplan@alliant.com

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: _____ Local: _____

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 DENTAL INSURANCE PLAN: *(Choose one)*

PLAN: ☐ HIGH OPTION ☐ LOW OPTION

INDICATE COVERAGE DESIRED: *(Choose one)*

☐ Member Only ☐ Member & Spouse/Domestic Partner ☐ Member & Child ☐ Member & Spouse/Domestic Partner & 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/DOMESTIC PARTNER'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.*

I hereby enroll for and authorize the necessary salary deductions for the premium to pay for insurance in the Voluntary Benefits Plan Dental Plan underwritten by MetLife Insurance Company. 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*

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

Group Policy # 122705