

# MetLife Dental Enrollment/Change Form

New  Change  Effective Date: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Employee  Plan A  
 Employee & Spouse  Plan B  
 Employee & Child(ren)  Plan C  
 Family

Employee Information

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent Information

Add/Delete	M/F	Relationship	Name	SS#	DOB

Signature: \_\_\_\_\_ Date: \_\_\_\_\_