Cornell University | Division of Human Resources

Endowed MetLife Dental Plan Enrollment Form

❒New enrollment
❒Change coverage
❒Cancel coverage: effective date _____

❒Dental Standard ❒Dental Plus

Employee Name (last, first, middle initial)		Social Security Number / /
Sex ( ) M ( ) F	Date of Birth / /	Employment Date / /
Home Address _____ City State Zip		
Campus Address	Telephone	Email

Please select the coverage level you would like to enroll in below:

Effective date: / /	Coverage: ( ) Individual ( ) Individual + Spouse/Domestic Partner ( ) Individual + Child(ren) ( ) Individual + Spouse/Domestic Partner + Child(ren)

If you wish to cover your spouse or domestic partner, please check spouse ❒ or domestic partner ❒ and complete the following:

Name of Spouse or Domestic Partner (last, first, middle initial)		Spouse/Domestic Partner Social Security Number / /
Date of Marriage/Partnership / /	Spouse/Domestic Partner Date of Birth / /	Name of Spouse/Domestic Partner Employer
Sex ( ) M ( ) F	If employed by Cornell, name of department:	

If you wish to cover your eligible dependent child(ren) or your domestic partner's child(ren), complete the following:

Name(s) of child(ren) (last, first, mi)	Date of Birth (mo/day/yr)	Male/Female	Relationship to you:	Social Security Number:

I hereby declare that the information provided is correct, and that to the best of my knowledge and belief, I am eligible for insurance under the terms of Cornell University's dental program for endowed employees. I hereby request the insurance thereunder to which I am entitled or to which I may become entitled. I authorize and understand that premiums will be retroactive to the eligibility date or qualifying event date. This means that double deductions will be taken from my paycheck if back premiums are owed.

Signature _____ **Date** _____