



The Upper New York Conference
OF THE UNITED METHODIST CHURCH

MetLife Dental Plan Election Form - Monthly Premium Cost
Effective 1/1/20 -12/31/20

Dental Plan (Basic Option)		Monthly Premium Cost
<input type="checkbox"/>	Single	\$0.00
<input type="checkbox"/>	Employee + Spouse	\$0.00
<input type="checkbox"/>	Employee + Child(ren)	\$0.00
<input type="checkbox"/>	Family	\$0.00

Select one

Dental Plan (Buy Up Option)		Monthly Premium Cost
<input type="checkbox"/>	Single	\$16.60
<input type="checkbox"/>	Employee + Spouse	\$33.00
<input type="checkbox"/>	Employee + Child(ren)	\$36.11
<input type="checkbox"/>	Family	\$53.09

Select one

Please indicate if you are requesting a change in the tier level of coverage:	Yes / No
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Circle one

*Note: If changing coverage level, please complete enrollment form attached.
If adding spouse or dependents please provide name, address, social security numbers and date of birth for those individuals.*

Waiver

I am declining dental benefits

Print Name

Signature Date

Coverage modifications can only be made during the plan year when attributable to a change in status (ie., marriage, divorce, birth, adoption, death or change in employment status)