DENTAL INSURANCE – ENROLMENT AND MODIFICATION

English Montreal School Board

VERY IMPORTANT: *If you are **modifying** your plan*, you must include **the event and date** that apply.
Note: You must file within 30 days of a life event. Please attach an explanatory note if necessary.

Date of enrolment or modification: Y M D

Reason for the request: ☐ Enrolment ☐ Modification Event:_____

1. PLAN MEMBER INFORMATION

Policy No. 97001, Division 8870 Certificate No.(modifications only) _____ Employee No. _____

First name _____ Last name _____

2. TYPE OF DENTAL INSURANCE COVERAGE

Dental insurance is **mandatory for full-time and part-time teachers in the Youth sector and for full-time teachers in the Adult and Vocational Educational sectors**. Please select "Teacher only" if you do not have dependents.

Dental insurance is **optional for your dependents** (spouse or children). To enrol your dependents, select the appropriate coverage depending on your situation.

Please select the coverage:

☐ Teacher only (Individual)
☐ Teacher and spouse (Couple)
☐ Teacher and dependent children (Single-Parent)
☐ Teacher, spouse and dependent children (Family)

3. DEPENDENTS INFORMATION

Complete this section for the dependents coverage you have selected.

	Last Name	First Name	Sex	Date of Birth
Spouse			☐ M ☐ F	Y M D
Child			☐ M ☐ F	Y M D
Child			☐ M ☐ F	Y M D
Child			☐ M ☐ F	Y M D

4. EXEMPTION (Please provide a proof of your spouse coverage)

☐ I refuse the dental insurance as I already have similar coverage with my spouse.

Spouse's Name _____ Spouse's Employer _____

Insurer's Name _____ Policy No. _____

5. PLAN MEMBER'S CONFIRMATION

I certify that the above information is true and complete.

_____ Y M D

Plan Member's Signature **Date**

WHERE TO RETURN THIS FORM (Please keep a copy of this form)

English Montreal School Board, Human Resources Department, Group Insurance
6000 Fielding Avenue
Montreal, QC H3X 1T4

ADMINISTRATOR'S CONFIRMATION – FOR OFFICIAL USE BY THE ENGLISH MONTREAL SCHOOL BOARD ONLY

I certify that the above information is true and complete.

Francine Girard _____ Y M D

Administrator's Name **Signature** **Date**