CIGNA Dental Enrollment/Change Form

For Active NYCT/MTA Bus/SIRTOA Employees

HR-BEN-623

Section 1 - Information and Instructions

The purpose of this form is to enroll in or change dental insurance.

Please submit a complete and signed copy of this form via:

Fax: 212-852-8700

Email: bscservice@mtabsc.org

If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section 2 - Employee Information

Print Name	Last First M.I.	BSC ID
		Pass #
Street Address		
City	State	Zip Code

If your address on your pay stub is incorrect, contact the Business Service Center, or log onto www.mymta.info and change your address online OR complete the HR-HRIS-012 Employee Data Change Form. An incorrect address will delay receipt of your new health insurance cards.

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐	Marital Status Date ___/___/___ MM DD YYYY	Phone
		Email

Section 3 – Coverage Election

Individual ☐ Family ☐

Check **ONE** of the following dental plans below **ONLY** if you are not enrolled in the Aetna High Option Plan. The Aetna High Option Plan includes dental.

☐ **CIGNA Dental Care (DHMO)**

☐ **CIGNA DPPO**

WAIVING COVERAGE

☐ I DO NOT WISH TO ENROLL IN DENTAL COVERAGE *

******Please note that your election to waive remains in effect until you change your election during a future Open Enrollment period. If you experience a Qualified Family Status Change which requires you to enroll, please contact the Business Service Center at 646-376-0123.*

Section 4 – Dependent Information

1. Please fill in all information for dependents you wish to enroll and submit Required Documentation (see Section 5). Documentation is required within 90 days from the effective date for a newborn dependent. Failure to submit documentation will result in the termination of your dependent's coverage.
2. Please fill in all information for any dependents you wish to add, remove or change.

DOMESTIC PARTNER

Please contact the Business Service Center for the Domestic Partnership Package if you wish to enroll a domestic partner. Your domestic partner will not be enrolled in health coverage unless an application is submitted and approved by the Benefits Department.

Indicate (A) Add, (R) Remove or (C) Change					Relationship (Check one)			Gender		Date of Birth		
A	R	C	Name	SSN	Spouse	Domestic Partner*	Child	F	M	Month	Day	Year

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Section 5 – Required Documentation

1. For a Spouse

A copy of your Marriage Certificate, Birth Certificate, and Social Security card are required. In place of a required Birth Certificate, any of the following official government documents can be submitted.

Any other official Government documents are:

- A letter from Social Security containing your spouse's date of birth
- Valid US Passport
- Valid Driver's License-New York
- Resident Alien Card
- Public Assistance ID Card
- Government Employment ID

AND

If your date of marriage is more than one year old, proof of joint ownership is required.

Both the enrollee's and spouse's name must be listed on the documentation of joint ownership. Where indicated, proof***** must be dated within the past 90 days. Examples include a copy of:

- Your most recent tax return showing "Married Filing Jointly" or "Married Filing Separately". Your spouse's name must appear on the tax form on the line provided on the line provided after the "married filing separately" status (or vice versa). Submit page 1 of the tax return.
- Homeowners/Renters Insurance Policy
- Credit Card Statement*****
- Loan Obligation or Bank Account Statement*****
- Pension/life insurance/will, designating your spouse as beneficiary
- Mortgage Statement /Rental/Lease Agreement or Property Tax Document*****
- Utility/phone/internet/cable bills*****

If you are removing a spouse due to divorce, please submit the first and last page of your divorce decree showing the court filing date.

2. For Children

- For a Natural-Born Child, a copy of:
  - Birth Certificate showing employee's name
  - Social Security Card
  - **Puerto Rican Birth Certificates issued prior to July 1, 2010 are unacceptable**

- For a Stepchild, or Legally Adopted Child, a copy of:
  - Birth Certificate
  - Social security card
  - Legal documentation concerning adoption/guardianship

Section 6 - Authorization

I do hereby certify that to the best of my knowledge the above information is true and correct.

My signature and date on this form certifies and warrants that all dependent eligibility information is true, correct and current. I also certify that dependent children from age 19 to 26 that I have enrolled in coverage are not eligible for another employer sponsored coverage.

Employee Signature	**Date**