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| MetLifelogo_black_MBC-DL | Initial Application  Renewal Acknowledgement |

**Benefits for General Dental Care provided by MetLife Health Plans, Inc.**

**Benefits for Specialty Care underwritten by Metropolitan Life Insurance Company** ACCEPTANCE AGREEMENT (APPLICATION & ACKNOWLEDGMENT)

GROUP DENTAL SERVICES

**Important Note: This Application and Acknowledgement should be signed and returned to us to ensure the commencement and/or continuation of your dental benefits plan.**

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| **ORGANIZATION** (full legal name) | | | | | **Group No.** |
|  | | | | |  |
| ORGANIZATION is a  Corporation  Partnership  Sole Proprietor  Government Agency  Union Trust | | | | | |
| Street / P. O. Box Number | | | | | |
| City       State  Zip | | | | | |
| **ORGANIZATION CONTACT** | | | | | |
| First Name | | Last Name | | Title | |
| Telephone | Ext. | | Fax | E-mail Address | |

METLIFE, subject to all the conditions and provisions of the Contract, and in reliance upon the statements of each enrollee of the ORGANIZATION in his or her enrollment/change request, shall provide the services and benefits and the other rights and privileges which are set forth in the Contract, which shall take effect on       1,      the “Effective Date”, and shall continue for a period of     year(s).

The ORGANIZATION is responsible for determining eligibility, except that part-time and disabled employees will not be eligible. If enrollees are employees, employees who commence work after the Effective Date, shall be eligible as determined by the ORGANIZATION.

If ORGANIZATION is multi-site, please note name and address of any subsidiary or affiliated companies to be included under the Contract on this Application and Acknowledgment. If the subsidiary or affiliated company is not listed, it will be excluded from this Contract. Formal documents govern all rights and benefits; for full and complete Contract information, please refer to your Contract.

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| **If group is multi-site, locations to be covered under the Contract** (must have been included in underwriting process) |
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It is understood that no person, except an authorized officer of METLIFE has the authority to modify, enlarge or vary any Contract or to waive any requirement in any Contract.

$      is submitted with this Application and Acknowledgment to be applied toward the first month’s prepayment fee.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

*In witness whereof, the parties have affixed their signatures to this Application and Acknowledgment as of the dates set forth below.*

# **ORGANIZATION**

Signed at: City       State       Date       ,

ORGANIZATION       Tax I.D. #

Authorized ORGANIZATION Representative

Signature Title

# **BROKER INFORMATION**

Broker Name       Broker License #       Phone

Street Address       City       State    Zip

E-mail Address

Signed at: City       State       Date

Broker’s Signature

**Metropolitan Life Insurance Company:**

200 Park Avenue, New York, New York 10166-0188

Signature:  Name: Isaac Torres Title: Assistant Secretary

**MetLife Health Plans, Inc.:**

501 Route 22, Bridgewater, NJ 08807

Signature:  Name: Isaac Torres Title: Secretary