COVERAGE TRANSFER FORM

Plans Effective January 1, 201_____

Company Name: ____

Exchange / Association: ______________________________

Company ID Number: ____

Type of Coverage to Transfer: ☐ Dental ☐ Vision (Use a separate form for each plan type)

#	Employee Name: Last, First	Social Security Number	Current Plan Name	New Plan Name	ADMIN USE ONLY New Plan Group#
1					
2					
3					
4					
5					
6					
7					
8					

Note: Most changes will require an updated Employer Participation Agreement.

If Applicable:

How many employees are currently enrolled in any MetLife Dental Plan? ☐ 1-5 ☐ 6-19 ☐ 20+

If you are changing Vision Plans, are you enrolling as: ☐ Matching Dental ☐ Stand Alone ☐ Voluntary

Authorized Company Signer (please print)	Title
Signature X	Date