



2009 Retiree Dental Enrollment Sheet

RETIREE INFORMATION

Name (Last, First, M.I.)

Address (Street, City, State, Zip)

Home Phone E-Mail

Social Security Number

Marital Status: Single Married Widowed

DENTAL ELECTION

I elect to enroll in the Aetna Traditional Dental (PPO) plan

Coverage level: Retiree Only (Single) Retiree & Dependent (2-Person) Retiree & Family

PERSONAL INFORMATION – Please list all dependents that you would like covered by the retiree dental plan.

Table with 4 columns: Name (Last, First, M.I.), Date of Birth (MM/DD/YYYY), Relationship, Social Security Number. Includes a row for the retiree and three empty rows for dependents.

SIGNATURE – Please read carefully and sign below.

My signature below acknowledges that I have read all information on both sides of this form.

Name: Date:

NOTE:

If I elect Emory's Retiree Dental plan, I hereby authorize all hospitals, physicians, medical service providers, pharmacists, and all other agencies or organizations (including insurers and pre-paid health plans) to permit my choice vendor or its representatives to see or obtain a copy of all medical, prescribed drugs, HIV, and mental health diagnoses, and insurance coverage records which pertain to me or any member of my family. This information will be used in connection with claims for benefits and utilization review and will be kept strictly confidential. This authorization shall remain valid for the term of this coverage. I understand that if a member is injured through the act or omission of another, the insurance vendor will require reimbursement for the benefits provided in an amount not to exceed any damages collected (where permitted by law).