



Employee Dental Plan Selection

V1102014

IMPORTANT INFORMATION:

Your employer will provide you with the dental plan name(s) he/she has selected that you can choose from. Review the Dental Plan Rates and Benefits Summary documents on the 'dental information' page of the MNSure website (www.mnsure.org). Please make your decisions and return this form to your employer by the date given to you by him/her.

If you have made a decision to purchase dental coverage, complete both this form and the Employee Application from our web site (www.mnsure.org). It can be found on the 'dental information' page under the 'enrollment forms' section. If you are waiving dental coverage, complete and return only this Employee Dental Plan Selection form. Your employer will return all documents to MNSure on your behalf.

Employer Company Name: _____

Employee Name: _____

Please select one of the following options.

Name of the dental plan you have selected (only one per family):

I elect to waive dental coverage (If you select the option to waive dental coverage, please complete page 2 of this form and return it to your employer.)

Name of Dependent	Relationship	Rate	Employer Contribution Percentage (%)	Employer Contribution (rate times %)	Premium Cost
<i>Example: Tom Smith</i>	<i>Self</i>	<i>\$50</i>	<i>0%</i>	<i>\$0</i>	<i>\$50</i>
1.					
2.					
3.					
4.					
5.					
6.					
Cost Summary				Total \$	Total \$



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Note: Attach more sheets as necessary to list all your dependents. A maximum of 3 dependent children, under the age of 19 on the effective date of coverage, are used to quote the total monthly premium.

Employer Company Name: _____

Name of the dental plan you have selected (only one per family):

Read & Sign this Enrollment

- I have provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal and state law if I intentionally provide false or untrue information.
- This is my dental insurance selection form.
- I hereby authorize my employer to deduct the employee portion of my coverage premiums from my payroll.

Employee Name (please print)

Employee Signature

Date (mm/dd/yyyy)