

**METLIFE DENTAL AND MES VISION
CHANGE REQUEST FORM**

Please type or print in black ink

CALIFORNIA ASSOCIATION OF REALTORS®

MetLife Group #: TS05726225

Class: _____

MES Group # 23540

MEMBER OR EMPLOYEE IDENTIFICATION - This section must be completed

SOCIAL SECURITY #:

CA REAL ESTATE LICENSE #

LAST NAME:

FIRST NAME:

MIDDLE INITIAL:

ADDRESS:

HOME PHONE:

BUSINESS PHONE:

CELL PHONE:

E-MAIL ADDRESS:

CHANGES – check mark all that apply

Change Dental Plan (Select one option): Standard Plus Plan Standard Basic Plan Premier Plus Plan Premier Basic Plan

Name Change: From: _____ To: _____

Add Dependent Cancel Dependent Relationship
 Dental Vision Dental Vision Spouse Domestic Partner

Reason: Open Enrollment Other: _____

Requested Effective Date: ____/____/____ Qualifying Event Date: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ Date of Birth: _____

Sex: M F

Add Dependent Cancel Dependent Relationship
 Dental Vision Dental Vision Child

Reason: Open Enrollment Other: _____

Requested Effective Date: ____/____/____ Qualifying Event Date: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ Date of Birth: _____

Sex: M F Is this child a full time student? Yes No

Add Dependent Cancel Dependent Relationship
 Dental Vision Dental Vision Child

Reason: Open Enrollment Other: _____

Requested Effective Date: ____/____/____ Qualifying Event Date: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ Date of Birth: _____

Sex: M F Is this child a full time student? Yes No

Note: For additional dependents please attach a separate sheet of paper.

EMPLOYEE OR C.A.R. MEMBER SIGNATURE

To the best of my knowledge and belief, all information on this form is correct and true.

X: _____ Date: _____

Please fax completed form to RealCare Insurance Billing Department: (707) 939-8450

NOVAK