2017 Enrollment Form
Michigan Dental Association
Underwritten by: United American Insurance Company

Enrollee Information (Please print)			
Name		Date of Birth	
Address		Social Security Number	
City		Sex	Phone Number
State	Zip Code	Medicare ID# *(From Medicare Id card):*	
Hospital (Part A) effective date *(from Medicare ID card):*		Medical (Part B) effective date *(from Medicare ID card):*	
Email Address		Date of Retirement	
Spouse Information (if enrolling)			
Name		Date of Birth	
Sex		Social Security Number	
Date of Retirement		Medicare ID# *(From Medicare Id card):*	
Hospital (Part A) effective date *(from Medicare ID card):*		Medical (Part B) effective date *(from Medicare ID card):*	

Please Choose Type of Coverage			
Effective Date:	**Enrollee Only**	**Enrollee & Spouse**	**Surviving Spouse**
Medical Plan 2 with Rx			
Medical Plan 3 with Rx			

Please sign and date below:	
Date:	**Enrollee Signature:**
Date:	**Spouse/Surviving Spouse Signature:**

If you are an authorized representative, you must sign above and provide the following information:
Name:_____

Address:_____

Phone Number:_____

Relationship to Retiree:_____

Please return signed election form and first month's payment to:
MDA Insurance
3657 Okemos Road, Suite 100
Okemos, MI 48864

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