

# Proof of Prior Coverage



You **MUST** complete this form and attach your proof of prior coverage.



## SECTION 1: Member information *(Please print.)*

First name	Middle name	Last name		
Address		City	State	ZIP
Date of Birth <i>(mm/dd/yyyy)</i>			Social Security Number	

## SECTION 2: Spouse information *(Please print. Leave blank if your spouse is not enrolled.)*

First name	Middle name	Last name
------------	-------------	-----------

## SECTION 3: Dependent child information *(Please print. Leave blank if your dependent child is not enrolled. If you have more than three children enrolled, please list them in the comments section on the back of this form.)*

### Dependent #1

First name	Middle name	Last name
------------	-------------	-----------

### Dependent #2

First name	Middle name	Last name
------------	-------------	-----------

### Dependent #3

First name	Middle name	Last name
------------	-------------	-----------

## SECTION 4: Prior coverage

Prior Coverage Effective Date *(mm/dd/yyyy)*

Prior Coverage End Date *(mm/dd/yyyy)*

Have you or your dependents had a recent claim for dental benefits denied by MetLife? *(Check yes or no)*

☐ Yes

☐ No

*If you have had a claim denied and we accept your proof of coverage, we'll automatically reprocess your claim.*



## Proof of Prior Coverage (continued)

---

### SECTION 5: Comments

---

### SECTION 6: How to provide proof of prior coverage and submit this form

Please provide us with proof of prior coverage or verification of coverage from your prior employer and/or dental carrier. Attach your proof or verification to this completed form and return it by:

**Mail:**

Metropolitan Life Insurance Company  
Attn: MCHCP National Accounts  
7800 Forsyth Blvd, Suite 450  
St. Louis, MO 63105

**Email:**

mchcp@metlife.com