

BENEFIT ENROLLMENT FORM



NEW EMPLOYEE CHANGE

GROUP NAME: Brewster Teachers Association Welfare Fund

EMPLOYEE LOCATION: _____ S.S# _____

EMPLOYEE NAME: Last _____ First _____ M I _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

BIRTHDATE: _____ HOME PHONE: _____ SEX: Male Female

MARITAL STATUS*: Single Married Separated Divorced DATE OF EVENT: _____

DOMESTIC PARTNER*: Add Delete DATE OF EVENT: _____

CHECK DESIRED COVERAGE: INDIVIDUAL FAMILY

DO YOU, YOUR SPOUSE OR YOUR PARTNER HAVE ANY OTHER DENTAL INSURANCE AT PRESENT? Yes or No

IF YOU HAVE ANSWERED "**YES**" TO THE ABOVE QUESTION, COMPLETE THE FOLLOWING WHERE APPLICABLE.

Name of Enrollee in Other Plan: _____

Enrollee's Place of Employment: _____ Date: _____

Address: _____

Name of Other Insurance Company: _____

Type of Coverage: INDIVIDUAL FAMILY

DEPENDENT LIST

Last Name	First Name	Date of Birth*	Relationship	Sex	Disabled	Student
1.					Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
2.					Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
3.					Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
4.					Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
5.					Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
6.					Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

ENROLLEE STATEMENT

I swear that all above information is true and complete.

SIGNATURE: _____ DATE: _____

WELFARE FUND STATEMENT

Date of Employment: _____ Effective Date: _____ Termination Date: _____

TRUSTEE _____ DATE _____

IMPORTANT: THIS COMPLETED FORM MUST BE RETURNED BEFORE ANY CLAIMS CAN BE HONORED

***Certification or Proof Required**