YORKTOWN CONGRESS OF TEACHERS WELFARE FUND

BENEFIT ENROLLMENT FORM

☐ ***New Enrollment*** ☐ ***Updated Enrollment***

Member's Name: _____ _____ _____
(LAST) (FIRST) (MI)

Home Address: _____ Male _____ Female _____
STREET

City/Town: _____ Tel#:_____ Email: _____

State: _____ Zip: _____ Employment Start Date: _____ School: _____

Election of Benefits: In accordance with new Federal health insurance law, you must elect which coverage you wish to continue and remit a fee for each ***that will be paid to the Fund from your YCT dues***. Each elected coverage cost $1 per annum (whether you enroll under individual or family). Please complete the form below indicating your choices:

Dental: *Individual* *Family* (CIRCLE ONE)

Vision: *Individual* *Family* (CIRCLE ONE)

Marital Status:

Single _____ Married _____ As of: _____ Widowed _____ Divorced _____ As of _____

Dependent Information

FULL NAME	DATE OF BIRTH	RELATIONSHIP	Are you, your spouse or dependent children covered by any other dental benefit program, which may pay for dental services? ☐ *Yes* ☐ *No* If yes, please list the name and address of the dental insurance company or administrator.
		Spouse	

I hereby certify that all information provided is complete and accurate to the best of my knowledge and understand that failure to provide complete and accurate information may result in denial or suspension of benefits. In addition, any person who knowingly and with intent to defraud any insurance company or this fund, files a statement of claim containing any materially false information or conceals for the purpose of misleading, information containing any fact material thereto, commits a fraudulent act, which is a crime.

MEMBER'S SIGNATURE: _____ **DATE:** _____