

Enrollment Form

This form must be completed, signed, dated, and returned to the NTA Benefit Trust Fund office before any Benefit Trust Fund claims will be honored. The Fund Trustees reserve the right to verify all statements.

Name (Last, First, Middle)

Date

Address: Street

City

State, Zip Code

Phone

Social Security #

Date Of Birth

Sex

Marital Status

School

Date Of Employment

Date Of Retirement

If you DO NOT want coverage, sign here and do not complete the rest of this form.

I hereby DECLINE coverage: (Signature)

Date

Spouse Name (Last, First, Middle)

Date Of Birth

Social Security #

Is your spouse covered by another dental plan?

Yes

No

Effective Date

Name of other insurance carrier

Do you want coverage for your spouse?:

Yes

No

Is your spouse vested (5+ years of service) in the New York State Teachers' Retirement System?

Yes

No

Are your dependents covered by another dental plan?

Yes

No

Name of dental carrier

For additional dependent coverage, complete the required information below for each dependent you want to cover.

Dependent

DOB

SSN

Relationship

Dependent

DOB

SSN

Relationship

I, the enrollee, understand that any false or misleading statement made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of myself and my dependents and/or legal actions appropriate to the prosecution of insurance fraud. I understand that it is my responsibility to notify the NTA Benefit Trust Fund office of any changes in the above information.

Member Signature:

Date