BENEFIT TRUST FUND

Phone: (845) 562-7988 • 52 Pierces Road Newburgh NY 12550

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 _____ 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 _____

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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 is my responsibility to notify the NTA Benefit Trust Fund office of any changes in the above information.

Member Signature: _____ Date _____