Ron Higgins, Chairperson

46 Davis Avenue
Poughkeepsie, NY 12603
Phone (845) 454-7002

ARLINGTON TEACHERS' ASSOCIATION WELFARE TRUST FUND ENROLLMENT/CHANGE FORM

Please complete this form, sign in the space provided and return to Ron Higgins ATA Office

EMPLOYEE NAME LAST	FIRST	MIDDLE	SS#	
HOME ADDRESS	CITY		STATE	ZIP
BIRTHDATE: MONTH: DAY: YEAR:	SEX: MALE ☐ FEMALE ☐	DESIRED COVERAGE ☐ INDIVIDUAL ☐ FAMILY		
TELEPHONE NUMBER	SCHOOL	POSITION		
DO YOU OR YOUR SPOUSE HAVE ANY OTHER DENTAL INSURANCE AT PRESENT? YES ☐ NO ☐		DATE OF EMPLOYMENT		

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:
Name of Other Insurance Company:
Type of Coverage: Individual Family

DEPENDENT LIST **(TO BE COMPLETED ONLY IF YOU ARE TAKING FAMILY COVERAGE)**

Last Name	First Name	Date of Birth	Relationship	Sex	Disabled	Student
1.					Yes ☐	Yes ☐
2.					Yes ☐	Yes ☐
3.					Yes ☐	Yes ☐
4.					Yes ☐	Yes ☐
5.					Yes ☐	Yes ☐

ENROLLEE STATEMENT

I swear that all above information is true and complete

SIGNATURE_____ DATE_____

TO BE COMPLETED BY A TRUST FUND REPRESENTATIVE

Effective Date: _____

TRUST FUND REPRESENTATIVE _____ **DATE** _____

(Signature)