

Ron Higgins, Chairperson
 Freedom Executive Park Ste102
 488 Freedom Plains Rd
 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 <input type="checkbox"/>	FEMALE <input type="checkbox"/>	DESIRED COVERAGE <input type="checkbox"/>	INDIVIDUAL <input type="checkbox"/>	FAMILY <input type="checkbox"/>
TELEPHONE NUMBER				SCHOOL		POSITION			
DO YOU OR YOUR SPOUSE HAVE ANY OTHER DENTAL INSURANCE AT PRESENT? YES <input type="checkbox"/> NO <input type="checkbox"/>						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 <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"/>

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)