

MINISINK VALLEY DENTAL PLAN ENROLLMENT FORM

[] NEW EMPLOYEE [] CHANGE

GROUP NAME: MINISINK VALLEY TA BENEFIT TRUST FUNDEMPLOYER NAME: MINISINK VALLEY CSD EMPLOYER LOCATION: Slate Hill, NY

EMPLOYEE NAME Last: _____ First: _____ Middle: _____ S.S.# _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE Month: _____ Day: _____ Year: _____ SEX: [] Male [] Female

MARITAL STATUS: [] Single [] Married [] Divorced [] Separated DATE OF EVENT: _____

CHECK DESIRED COVERAGE: [] INDIVIDUAL [] FAMILY

DO YOU OR YOUR SPOUSE HAVE ANY OTHER DENTAL INSURANCE AT PRESENT? [] YES [] NO

IF YOU ANSWERED "YES" TO THE ABOVE QUESTION, COMPLETE THE FOLLOWING.

Name of Enrollee in Other Plan: _____

Enrollee's Place of Employment: _____ Date: _____

Address: _____

Name of Other Insurance Company: _____ Policy #: _____

Type of Coverage: [] Individual [] Family

DEPENDENT LIST

Last Name	First Name	Date of Birth	Relationship	Sex	Disabled	Student
					[] Yes	[] Yes
					[] Yes	[] Yes
					[] Yes	[] Yes
					[] Yes	[] Yes
					[] Yes	[] Yes
					[] Yes	[] Yes

ENROLLEE STATEMENT*I swear that all above information is true and complete.*

SIGNATURE: _____ DATE: _____

EMPLOYER STATEMENT

WORK STATUS: [] FULL-TIME [] PART-TIME [] ON LEAVE

Date of Employment: _____ Effective Date: _____ Termination Date: _____

MINISINK REPRESENTATIVE: _____ DATE: _____

(Signature)