ENROLLMENT AND DEPENDENT INFORMATION

(PLEASE PRINT – MUST BE FILLED IN WITH INK)

1. Members Full Name:_____ _____
(LAST NAME) (FIRST NAME)

2. Address:_____ _____ _____ _____
(STREET NO) (CITY) (STATE) (ZIP CODE)

3. Home Phone:_____ 4. Work Phone_____ 5. Cell Phone_____

6. E-mail:_____ 7. Birthdate:___/___/_____ 8. SSN: _____-_____-_____

9. Check One: Single:_____ Married_____ Widowed_____ Divorced_____ Legally Separated_____

10. School Name:_____ Hired Date:_____ Retired Date:_____

Dependent Information (Dependents over 19 years of age, must be full time student)
Paid bursar's bill specifying semester/terms for ALL dependents ages 19-23 (Must be submitted every semester)

	Name	Date of Birth	Sex M/F	SSN
Spouse				
Dependent #1				
Dependent #2				
Dependent #3				
Dependent #4				
Dependent #5				
Dependent #6				

12. You may name one or more beneficiaries. Use full name. (If more space is needed, continue on other side).

_____
PRIMARY BENEFICIARY RELATIONSHIP TO EMPLOYEE ADDRESS

_____
CONTINGENT BENEFICIARY RELATIONSHIP TO EMPLOYEE ADDRESS

13. Spouse's Employer_____ Address of Employer_____

14. Are you or your spouse covered by any other Dental Plan?_____

15. Is the other plan a group or an individual plan:_____

16. Who is the policyholder?_____

Under penalty of perjury, including, but not limited to, prosecution for insurance fraud and a permanent termination of benefits from this fund, I attest that the above is true and accurate to the best of my knowledge. I also promise to notify the Fund at 212-505-5050 if any of the aforementioned information should change.

Date_____ Signature_____
(DO NOT PRINT)

BENEFICIARY DESIGNATION FORM
GROUP LIFE AND GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
First Unum Life Insurance Company
Provident Life and Casualty Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI)	Social Security Number

Employer Name	Check the coverages listed below to which this beneficiary designation applies: ☐ Basic Life ☐ Supplemental Life ☐ AD&D ☐ All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 4: Signature

X

Employee Signature **Date**

DOBBS FERRY UNITED TEACHERS WELFARE FUND
DENTAL AND VISION BENEFITS ELECTION FORM

Member Information:

Last Name	First Name	Middle Initial (MI)
Mailing Address		Last 4 of SS#
City	State	Zipcode
Date of Birth (Month/Day/Year)		

ACCEPTANCE OF COVERAGE ***COMPLETE THIS SECTION IF YOU WISH TO HAVE DENTAL AND VISION COVERAGE** **

If you are member of the DFUT, DF Custodial Unit or the CSEA, separate contribution payments of $1.00 for dental coverage and $1.00 for vision coverage will be remitted to he Welfare Fund on your behalf from your union dues.

☐ **YES I WISH TO ENROLL IN THE WELFARE FUND DENTAL PLAN:**

I understand by checking the box above I am electing to enroll in dental benefits and give permission for $___ to be deducted from my union dues.

I understand that if I do <u>not</u> check this box I am <u>declining</u> dental benefits.

☐ **YES I WISH TO ENROLL IN THE WELFARE FUND VISION PLAN:**

I understand by checking the box above I am electing to enroll in vision benefits stated and give permission for $__ be deducted from my union dues.

I understand that if I do <u>not</u> check this box I am <u>declining</u> vision benefits.

Signature of Member_____**Date**_____

_____

_____ **FUND**

DECLINATION OF COVERAGE

(DENTAL AND/OR VISION BENEFITS)

Member Name Last_____ First _____ Middle_____

Address _____

Social Security Number _____ Date of Birth _____

This is to acknowledge and certify that I am currently a covered member of the _____ ("Fund").

However, effective upon my signing of this form, I hereby decline and waive further coverage of the following Fund benefits for myself and any of my eligible dependent(s) currently enrolled in such benefits (please place a "check mark" below next to the benefits you wish to decline):

____ **DENTAL BENEFITS** ____ **VISION BENEFITS**

I hereby agree to indemnify and make whole the _____Fund, its heirs and assigns against any and all liability and/or loss arising out of my request to decline and waive further coverage of these benefits for myself and any eligible dependents currently enrolled.

Member's Signature _____ Date _____

Sworn to before me this
_____ day of _____, 20__.

_____
Notary Public