





**Additional Documentation Checklist**

If applicable, please send in copies of the following documentation along with this completed form:

- Social Security Card(s)
- Birth Certificate(s)
- Marriage Certificate or QDRO/Divorce Documents
- Death Certificates
- Proof of Disability for all disabled dependents
- PAID bursar's bill specifying semester/terms for all dependents aged 19-25
- English translation for all foreign documents submitted

**Additional Coverage**

Do you, or any of your dependents covered, also have coverage through another dental or vision plan? (Please check one)  YES  NO

If YES, please complete the information in the chart below for each covered individual who is enrolled in the plan:

Other Coverage	Last Name	First Name	Date of Birth	Relationship to Employee

**Signature**

**Member Signature**

**Date**

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**Member Waiver Statement**

I certify that I have been given an opportunity to participate in the Benefits Plan sponsored by the Bronxville Public School Employees' Trust. I understand fully the benefits available to me and I decline to participate in the plans being offered.

**Waiver Signature**

**Date**

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**Mail Completed Form To:**  
Bronxville School District Office  
ATTN: Dawn Mulvey  
177 Pondfield Road, Bronxville, NY 10708

**Questions? You can call our Customer Service Department at (914) 250 – 0700.**