



Group Name: Mamaroneck Teachers Association

All fields are required. Please Print.

Date of Birth

Zip

Email

Please check one: ☐ New Hire ☐ Open Enrollment ☐ Life Status Change

Please complete the below for all to be covered under the Benefit Plan:

[illegible]



DANIEL H. COOK ASSOCIATES INC

Additional Documentation Checklist

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

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

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

I certify that the information provided in this enrollment form is true to the best of my knowledge.

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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 Mamaroneck Teachers Association. 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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Hand in Completed Form To:

MTA office - MHS, Rm. N-101

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