

Enrollment Form

Group Name: Washingtonville Teachers Association

	Memb	er Informatio	n			
II fields are required. Please Pr	int.					
Last Name	First Name	Social	Social Security No.		Date of Birth Zip	
Street Address	City	State		Zip		
Date of Hire	Effective Date	Phone	Phone Number		Email	
Marital Status:	□ Married		☐ Divorced or Separated		□ Widowed	
Please check one: New			☐ Life Statu	us Change		
Please complete the be		Coverage	ntal or Visio	on Plans as d	enendents:	
Last Name	First Name	Social Security No.	Sex (M/F)	DOB MM/DD/YYYY	Full Time Student? (Over 19 years old)	
ouse					N/A	
ld					☐ Yes ☐ No	
d					☐ Yes ☐ No	
d					☐ Yes☐ No	
d					☐ Yes☐ No	
d					☐ Yes ☐ No	



If applicable, please send in copies of the following documentation along with this completed form: Social Security Card(s)	Additional Documentation Checklist						
Birth Certificate(s)	If applicable, please send in copies of the following documentation along with this completed form:						
dependents Marriage Certificate or QDRO/Divorce Documents	□ Social Security Card(s) □		•				
Additional Coverage Do you, or any of your dependents covered, also have coverage through another dental or vision plan? (Please check one) 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 Member Signature The information provided is true to the best of my knowledge. Date	☐ Birth Certificate(s) ☐						
Do you, or any of your dependents covered, also have coverage through another dental or vision plan? If YES, please complete the information in the chart below for each covered individual who is enrolled in the plans. Other Coverage Last Name First Name Date of Birth Relationship to Employee Member Signature The information provided is true to the best of my knowledge. Date Member Waiver Statement I certify that I have been given an opportunity to participate in the Benefits Plan sponsored by the Washingtonville Teachers Association. I understand fully the benefits available to me and I decline to participate in the plans being offered.		semester/terms for <u>all</u>					
NO NO NO NO NO NO NO NO NO NO NO NO NO NO NO		Additional Coverage					
Other Coverage Last Name First Name Date of Birth Relationship to Employee Signature Signature	Do you, or any of your dependents covered, also have coverage through another dental or vision plan? Output Do you, or any of your dependents covered, also have coverage through another dental or vision plan? NO						
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Waiver Signature Date							
	Waiver Signature Date						
/ ``							



E-mail Completed Form To:

Susan Mazza
Benefits Coordinator for Washingtonville Central School District
smazza@wcsdk12.org

845-497-4000 ext. 27040