DANIEL H. COOK
ASSOCIATES INC

Enrollment Form

Group Name: Warwick Valley Teachers Benefit Trust Fund

Member Information

All fields are required. Please Print. Please indicate if you have an ADDRESS CHANGE Yes _____ No _____

Last Name	First Name	Social Security No.	Date of Birth
Street Address	**City**	**State**	**Zip**
Date of Hire	**Effective Date**	**Phone Number**	**Email**

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

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

Coverage

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

	Last Name	First Name	Social Security No.	Sex (M/F)	DOB MM/DD/YYYY
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					

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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
- ☐ English translation for all foreign documents submitted
- ☐ Proof of Full-Time Student

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.

Member Waiver Statement

I certify that I have been given an opportunity to participate in the Benefits Plan sponsored by the Warwick Valley Teachers Benefit Trust Fund. I understand fully the benefits available to me, and I decline to participate in the plans being offered.

Waiver Signature **Date**

Trustee Signature **Date**



Please Email Form To:
Eligibility.dept@dhcook.com



Please Mail Completed Form:
Warwick Valley Teachers Trust Fund, c/o Daniel H. Cook Associates, Inc.
1040 Avenue of the Americas, 24th Floor, New York, NY 10018

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

Beneficiary Information

Warwick Valley Teachers offer a death benefit of $2,000.00 which is reimbursed for Active members only.

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) (check only one box), I hereby revoke any previous beneficiary designation(s). Please complete all requested information below.

Employee Name:	Employee ID #:	Last 4 of Social Security Number:
Employee Address:		Telephone Number:
Employer: **WARWICK VALLEY TEACHERS BENEFIT TRUST FUND**		Email:

NAMING YOUR BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact Daniel H. Cook's eligibility department at (914) 250 – 0700.

PRIMARY BENEFICIARY(IES)

Name: _____ **Date of Birth:** _____

Address: _____ **Telephone #: ( )** _____

Social Security Number: _____ **Relationship:** _____ **Benefit Percent:** _____**%**

Name: _____ **Date of Birth:** _____

Address: _____ **Telephone #: ( )** _____

Social Security Number: _____ **Relationship:** _____ **Benefit Percent:** _____**%**

Name: _____ **Date of Birth:** _____

Address: _____ **Telephone #: ( )** _____

Social Security Number: _____ **Relationship:** _____ **Benefit Percent:** _____**%**

CONTINGENT BENEFICIARY(IES)

Name: _____ **Date of Birth:** _____

Address: _____ **Telephone #: ( )** _____

Social Security Number: _____ **Relationship:** _____ **Benefit Percent:** _____**%**

Name: _____ **Date of Birth:** _____

Address: _____ **Telephone #: ( )** _____

Social Security Number: _____ **Relationship:** _____ **Benefit Percent:** _____**%**

Name: _____ **Date of Birth:** _____

Address: _____ **Telephone #: ( )** _____

Social Security Number: _____ **Relationship:** _____ **Benefit Percent:** _____**%**

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies)

Signature of Employee: _____ **Date:** _____



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