



Group Name: Warwick Valley Teachers Benefit Trust Fund

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

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 | ☐ Proof of Full-Time Student |
| ☐ Marriage Certificate or QDRO/Divorce Documents | | |

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 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

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Trustee Signature

Date

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



Please Mail Completed Form:
Warwick Valey 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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