FALLSBURG TEACHERS ASSOCIATION TRUST
DENTAL ASSISTANCE PLAN
ENROLLMENT FORM

Employee Name: *(Last, First)*			**Social Security #:**
Address:			**Date of Employment:**
City:	**State:**	**Zip:**	**Phone No:** ( )

TYPE OF ENROLLMENT				EFFECTIVE DATE	TYPE OF COVERAGE			
☐	New Application				☐	Employee Only		
☐	Reinstatement				☐	Employee & One Dependent		
☐	Termination				☐	Employee & Family		
☐	Self-Pay							
☐	Change *(Reason for Change):*				☐	**ADMIN**	☐	**CAFETERIA**
☐	Marriage	☐	Divorce		☐	**CUSTODIAL**	☐	**FTA**
☐	Birth	☐	Death		☐	**SRP**	☐	**UNAFIL**
☐	Retired	☐	Other		☐	**RETIRED**	☐	**COBRA**

Add	Delete	Relationship	Name Last	First	MI	Date of Birth (MM/DD/YYYY)	Full Time Student*	Social Security #
☐	☐	Self ☐ Male ☐ Female						
☐	☐	☐ Husband ☐ Wife						
☐	☐	☐ Son ☐ Daughter					☐ Yes ☐ No	
☐	☐	☐ Son ☐ Daughter					☐ Yes ☐ No	
☐	☐	☐ Son ☐ Daughter					☐ Yes ☐ No	
☐	☐	☐ Son ☐ Daughter					☐ Yes ☐ No	
☐	☐	☐ Son ☐ Daughter					☐ Yes ☐ No	
☐	☐	☐ Son ☐ Daughter					☐ Yes ☐ No	

***Dependent Children age 19-26 years must have proof of full time enrollment in college to have coverage.**

Other Dental Coverage:

Is there coverage under any other group dental plan available to you or any member of your family? ☐ Yes ☐ No				
If Yes, Policyholder's Name:				
Insurance Company Name:		Relationship: ☐ Self ☐ Spouse ☐ Child		Social Security #:
Address:				Policy #:
City:	State:	Zip:	Plan Type: ☐ Self Only ☐ Self and Family	
			Coverage Type: ☐ Health ☐ Dental ☐ Drug ☐ Vision	

Signatures:

Print Employee Name:	Employee Signature: X	Date:
Print Employer Name:	Employer Signature: X	Date: