ROSLYN TEACHERS ASSOCIATION BENEFIT FUND

Benefit Enrollment Form

☐ New Enrollment ☐ Change Enrollment

Member's Name (Last) _____ (First) _____ (MI) _____

Home Address (Street) _____

(City/Town) _____(State) _____ (Zip) _____

Tel. #_____ Employment Start Date _____ School _____ Date of Birth _____

Social Security No_____ - _____ - _____ Home E-mail: _____

Single___Married____Domestic Partner___Separated___Divorced___ Date of Marriage/Dom.Ptr./Sep/ Divorce _____

Election of Benefits: (circle one)

Dental: Individual Family

Vision: Individual Family

All elections are binding upon the member and his/her eligible dependents.

Dependent Information (Affidavit is required for domestic partner registration).

First and Last Name	Date of Birth			Relationship
	M	D	YR	

Are you, your spouse/domestic partner or dependent children covered by any other dental and/or optical benefit program which may pay for those services? Yes No

If yes please list the name and address of the dental and/or optical insurance company or administrator.

_____

Life Insurance: Primary Beneficiary Designation

Last Name	First Name	Relationship	Date of Birth	Address	Social Security Number	Benefit Percentage (%)

Life Insurance: Secondary/Contingent Beneficiary Designation

Last Name	First Name	Relationship	Date of Birth	Address	Social Security Number	Benefit Percentage (%)

I hereby certify that all information provided above is complete and accurate to the best of my knowledge and understand that failure to provide timely, complete and accurate information may result in denial or suspension of benefits. In addition, any person who knowingly and with intent to defraud any insurance company or this Fund, files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime.

MEMBER'S SIGNATURE DATED

REVISED 10/25