Annual Enrollment Update Form

WTABT

P.O. Box 305
Gardiner, NY 12525

This form must be updated **yearly**, then signed and **mailed** to the WTA Benefit Trust by **June 15th**. Claims submitted after June 15th will be held until the Benefit Trust receives this completed form. The Fund's Trustees have the right to verify all statements. Please **print** all information in **blue or black** pen.

Last Name _____ (Legal) First Name _____ MI _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Social Security Number _____

DOB _____ Sex _____ Marital Status _____ Building Assignment / Retiree _____

Do you have any other Health/Dental Insurance (ex: MVP) for dependents under 19? Yes_____ No_____

Is there other dental coverage? Spouse/Partner: Yes_____No_____

Children: Yes_____No_____

If yes, name of other dental insurance carrier/plan:_____

Fill in the information below for your spouse/eligible dependents by listing their name, sex, date of birth, social security number and the dependents' relationship to you.

Legal Name of spouse/domestic partner _____ Sex _____ DOB _____ SS# _____

Legal Name of eligible dependent _____ Sex _____ DOB _____ SS# _____ Relationship _____

Legal Name of eligible dependent _____ Sex _____ DOB _____ SS# _____ Relationship _____

Legal Name of eligible dependent _____ Sex _____ DOB _____ SS# _____ Relationship _____

Legal Name of eligible dependent _____ Sex _____ DOB _____ SS# _____ Relationship _____

I certify that all my responses on this form are accurate and correct. It is my responsibility to notify the WTA Benefit Trust Office of any changes in the above information.

Signature of the WTABT Member _____ Date _____