SOMERS FACULTY ASSOCIATION TRUST FUND

DENTAL / VISION / SECONDARY BENEFIT / LIFE INSURANCE ENROLLMENT / CHANGE FORM

☐ NEW EMPLOYEE ☐ CHANGE ☐ TERMINATION

EMPLOYEE NAME: **Last** _____ **First** _____ **M I**____ **S.S. #**_____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

BIRTHDATE: _____ SEX: ☐ Male ☐ Female

Personal Email: _____ Phone Number: _____

MARITAL STATUS*: ☐ Single ☐ Married ☐ Separated ☐ Divorced DATE OF EVENT: _____

CHECK COVERAGE INDIVIDUAL ☐ FAMILY ☐

DO YOU OR YOUR SPOUSE HAVE ANY OTHER DENTAL and/or VISION INSURANCE AT PRESENT? YES ___ or NO ___

IF YOU HAVE ANSWERED **"YES"** TO THE ABOVE QUESTION, COMPLETE THE FOLLOWING WHERE APPLICABLE.

Name of Enrollee in Other Plan: _____

Enrollee's Place of Employment: _____ Date: _____

Address: _____

Name of Other Insurance Company: _____ Policy # _____

Type of Coverage: ☐ INDIVIDUAL ☐ FAMILY

DEPENDENT LIST

Last Name	First Name	Social Security #	Date of Birth	Relationship	Sex	Student*	Disabled**

****Disabled dependent certification required – Complete separate medical certification form**

ENROLLEE STATEMENT

I swear that all above information is true and complete.

SIGNATURE: _____ DATE: _____

EMPLOYER STATEMENT

WORK STATUS: Full-Time ☐ On Leave ☐ COBRA (send packet Employee Term) ☐

Date of Employment: _____ Effective Date: _____ Term Date: _____ Retire Date:_____

EMPLOYER REPRESENTATIVE _____ DATE _____