

WELFARE FUND

United Federation of Teachers

52 Broadway • New York, New York 10004

(212) 539-0500

DENTAL ENROLLMENT/TRANSFER FORM

P A R T A	I choose:		Reason for submission:	
	<input type="checkbox"/> UFT Welfare Fund Scheduled Benefit Plan <input type="checkbox"/> Dentcare (HMO)* <input type="checkbox"/> UFT Florida Dental Discount Plan* (Permanent Florida residents only.)		<input type="checkbox"/> New hire† <input type="checkbox"/> Transfer Period <input type="checkbox"/> Permanent move in or out of an area.†	
	* Members that elect to participate in this plan are not eligible to receive any other dental benefits from the UFT Welfare Fund.		†Date of event: ____/____/____ (Must be submitted within 31 days of event.)	
Membership Status (check one only)				
<input type="checkbox"/> Employee		<input type="checkbox"/> Retiree		<input type="checkbox"/> COBRA <input type="checkbox"/> Pre-70 Retiree

UFT Welfare Fund—Member Information (PLEASE PRINT)

P A R T B	Last Name, First Name, Middle Initial			Social Security Number / /	
	Home Street Address			City, State	
	Zip Code	Work Phone ()		Home Phone ()	
	Marital Status (Must complete) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed, Divorced <input type="checkbox"/> Domestic Partner Spouse/Domestic Partner's SS#: ____/____/____ Is spouse/domestic partner a UFT member? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you covered for dental benefits by another group plan or government agency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of other company/organization providing benefits _____					

INSTRUCTIONS:

P A R T C	If you selected Dentcare (HMO):				
	<ul style="list-style-type: none"> • Fill in name and code number (the number which precedes name) of the Dentist you have selected from the "Directory of Participating Providers." • You may select a different dentist for each family member within the Dentcare Plan. • If you only enter one Provider Code, all family members will automatically be enrolled in that office. • Benefits are only available at your selected participating dental office. 				
	If you selected the UFT Florida Dental Discount Plan:				
	<ul style="list-style-type: none"> • Fill in name and code number from the "Directory of Participating Providers for the UFT Florida Dental Discount Plan" • Only one dentist may be selected for the entire family. • Benefits are only available at your selected participating dental office. 				
	Relationship	Name (include last name if different from your last name)	Birth Date Mo/Day/Yr	Sex	Provider Name and Code Number (Must be completed if selecting Dentcare (HMO) or UFT Florida Dental Discount Plan)
	Employee				
	Spouse				
Child					
Child					
Child					
Child					

Upon completion of the Enrollment/Transfer Form, please sign and mail it to the UFT Welfare Fund at the address above—
Attention: DENTAL ENROLLMENT.

Date: _____ Signature: _____