WELFARE FUND
United Federation of Teachers
52 Broadway • New York, New York 10004 (212) 539-0500

DENTAL ENROLLMENT/TRANSFER FORM

PART A

I choose:
- ☐ UFT Welfare Fund Scheduled Benefit Plan
- ☐ Dentcare (HMO)*

Reason for submission:
- ☐ New hire†
- ☐ Transfer Period
- ☐ Permanent move in or out of an area.†

*** Members who 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)

☐ Employee	☐ Retiree	☐ COBRA	☐ Pre-70 Retiree

UFT Welfare Fund—Member Information (PLEASE PRINT)

PART 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)*
☐ Single ☐ Married ☐ Widowed, Divorced ☐ Domestic Partner Spouse/Domestic Partner's Social Security#: ____/____/____
Is spouse/domestic partner a UFT member? ☐ Yes ☐ No

Are you covered for dental benefits by another group plan or government agency? ☐ Yes ☐ No
If yes, name of other company/organization providing benefits ______________________________.

INSTRUCTIONS:

PART C

If you selected Dentcare (HMO):
- 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 spouse/domestic partner is a UFT member, only one can join Dentcare.

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)
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: ______________________________