CWA LOCAL 1180 BENEFITS FUNDS

SCHEDULED DENTAL BENEFIT PLAN

ENROLLMENT FORM

6 Harrison Street, New York, NY 10013-2898
(212) 966-5353 Out-Of Area (888) 966-5353

Active ☐ Retired ☐

1. ______________________________ 2. SSN or ID#______________
Last Name First Name MI

3. Home Address ______________________________

______________________________ 4. ______________
City State ZIP Home Phone No.

5. Date of Birth ____/____/______ 6. Gender: F ☐ M ☐
DD/MM/YYYY

7. Other Dental Coverage ____________________ Group # ____________

8. Marital Status: Single ☐ Married ☐ Domestic Partnership ☐

Email Address: ______________________________

9. Does Your Spouse/Domestic Partner Have Other Dental Coverage: Yes ☐ No ☐

Spouse's/Domestic Partner's Insurance Carrier ____________ Group # ____________

10. List below the names of your spouse/partner and dependents eligible for dental benefits under the Scheduled Dental Benefit Plan: (Dependent children under 19 yrs of age/23 yrs of age if full-time student)

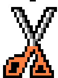
LAST NAME	FIRST NAME	MI	SSN	RELATIONSHIP (CIRCLE)	DATE OF BIRTH
				H W P D S	MM / DD /YYYY
				H W P D S	MM / DD / YYYY
				H W P D S	MM / DD / YYYY
				H W P D S	MM / DD / YYYY
				H W P D S	MM / DD / YYYY
				H W P D S	MM / DD / YYYY

MEMBER'S SIGNATURE ______________________________ DATE______________

How to Enroll?

1. Complete the enrollment application above entirely and be sure to sign and date where indicated.
2. Insert the application in the enclosed return envelope and mail to the address displayed above.

NOTE: Be sure to mail with the proper postage. Your Annual Open Enrollment Application must be received by the Fund Office no later than the stated deadline



ENROLLMENT APPLICATION