Warwick Valley Teacher's Benefit Trust ENROLLMENT FORM

The Preferred Group
PO Box 15136
Albany, NY 12212
(866) 989-8997

☐ NEW EMPLOYEE ☐ ADD DEPENDENTS ☐ RETURN FROM LEAVE

☐ NEW MARRIAGE / CHANGE Name/Address Maiden Name_____

GROUP NAME: Warwick Valley Teacher's Benefit Trust
EMPLOYER NAME Warwick Valley Central School District EMPLOYER LOCATION _____

EMPLOYEE NAME: Last _____ First _____ M I___ SS# _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

BIRTHDATE: _____ PHONE #: _____ SEX: ☐ Male ☐ Female

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

COVERAGE TYPE: ☐ VISION ☐ DENTAL ☐ PRESCRIPTION MODE: ☐ SINGLE ☐ FAMILY

DO YOU OR YOUR SPOUSE HAVE ANY OTHER DENTAL OR VISION INSURANCE AT PRESENT? ☐ YES ☐ 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

Name (Last, First)	Date of Birth*	Relationship	Sex	Disabled	Student
1.				**Yes** ☐	**Yes** ☐
2.				**Yes** ☐	**Yes** ☐
3.				**Yes** ☐	**Yes** ☐
4.				**Yes** ☐	**Yes** ☐
5.				**Yes** ☐	**Yes** ☐
6.				**Yes** ☐	**Yes** ☐

ENROLLEE STATEMENT

I WISH TO ENROLL IN THE HEALTH REIMBURSEMENT ARRANGEMENT SO I CAN RECEIVE UP TO THE PLAN YEAR MAXIMUM IN REIMBURSEMENTS FOR PRESCRIPTION COPAYS PER YEAR AND I ACKNOWLEDGE THAT I AM ENROLLED IN THE WARWICK VALLEY CENTRAL SCHOOL DISTRICT MEDICAL PLAN OR I AM ENROLLED IN A GROUP MEDICAL PLAN OTHER THAN A PLAN INDIVIDUALLY PURCHASED THROUGH A HEATH PLAN MARKETPLACE OR EXCHANGE. PLEASE PROVIDE THE DISCLOSURE NOTICE THAT THE PLAN COMPLIES AS A MINIMUM COVERAGE PLAN AS DESCRIBED IN THE AFFORDABLE CARE ACT.

SIGNATURE: _____ DATE: _____

TRUSTEE SIGNATURE _____ DATE: _____

Revised 9/2021

Please fill out Waiver of Coverage on reverse side to DECLINE enrollment

Waiver of Coverage: **COMPLETE THIS SECTION ONLY IF WAIVING COVERAGE**

I understand that I am being offered the plan mentioned on the reverse side of this form and am waiving (declining) enrollment and am forfeiting all reimbursement dollars associated with these plan options.

- PLEASE CHOOSE ONE OF THE FOLLOWING IF YOU ARE DECLINING ENROLLMENT -

WAIVED COVERAGES: VISION, DENTAL, AND PRESCRIPTION (up to the plan year maximum 7/1/2017)

☐ **I DECLINE ENROLLMENT IN THE WARWICK VALLEY TEACHER'S BENEFIT TRUST PLAN(S) CHECKED OFF ABOVE**

- **I understand that I will receive no additional compensation if I waive enrollment.**
- **I understand that waiving enrollment means that I cannot enroll until the next Open Enrollment period (Except if there is a Special Enrollment or mid-year change of status opportunity).**

Signature of Employee_____

Date_____