

UTU - MTA TRUST FUND - 2021 ENROLLMENT CARD

PLEASE
PRINT

FOR OFFICE USE

HEALTH PLAN: _____

DENTAL PLAN: _____

EFFECTIVE DATE: _____

NAME _____
LAST FIRST IN

ADDRESS _____
NUMBER STREET CITY STATE ZIP CODE

SSN _____ HOME PHONE NO (____) _____

BIRTH DATE _____ GENDER M ☐ F ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐

BADGE NO _____ DIVISION _____ SENIORITY DATE _____

BENEFICARY _____ RELATIONSHIP _____ DOB _____

I CHOOSE FOR MY HEALTH CARE: ☐ UTU-MTA MEDICAL PLAN (PPO) ☐ KAISER (HMO)
☐ UNITEDHEALTHCARE Harmony (HMO) ☐ UNITEDHEALTHCARE Value (HMO)

I CHOOSE FOR MY DENTAL: ☐ DELTA DENTAL (PPO) **FULL TIME ONLY** ☐ DENTAL HEALTH SERVICES DHS OFFICE NO _____

PLEASE ADD DEPENDENTS ON OTHER SIDE



I CERTIFY THAT THE INFORMATION ON THIS CARD IS CORRECT AND AUTHORIZE THE RELEASE OF ANY DOCUMENTS TO THE ADMINISTRATION FOR VALIDATION OF COVERAGE. FURTHERMORE, I HEREBY AUTHORIZE MTA (EMPLOYER) TO DEDUCT FROM MY SALARIES OR WAGES, FROM TIME TO TIME UNTIL FURTHER NOTICE IN WRITING, AMOUNTS EQUAL TO THE CONTRIBUTIONS REQUIRED OF ME FOR THE PAYMENT OF PREMIUMS ON GROUP INSURANCE POLICIES ISSUED TO THE UTU-MTA TRUST FUND.

SIGNATURE _____ TODAY'S DATE _____

DEPENDENTS:

				BIRTH DATE			SOCIAL SECURITY	
	LAST NAME	FIRST	IN	M	F	MONTH / DAY / YEAR	(REQUIRED AS OF 2012)	
SPOUSE						/ /	-	-
CHILD						/ /	-	-
CHILD						/ /	-	-
CHILD						/ /	-	-
CHILD						/ /	-	-
CHILD						/ /	-	-
CHILD						/ /	-	-
CHILD						/ /	-	-
CHILD						/ /	-	-