



POLICYHOLDER (employer) Monticello Teachers Association Benefit Trust Fund
GROUP ENROLLMENT AND/OR CHANGE FORM

EMPLOYEE (last, first, middle initial) _____ F M
Street _____ Date of Birth (mm/dd/yyyy) ___/___/_____
City _____ State _____ ZIP _____ Phone (____) _____
Hours worked per week _____ Annual Salary \$ _____ Date of F/T hire (mm/dd/yyyy) _____
Job title _____ Social Security Number _____

TYPE OF COVERAGE (Policy Number) (check all that apply)
Not all policies may be available through your employer.

- Dental _____
- Vision _____
- Life _____
- GMRP _____
- XGMM _____
- LTD _____

NEW ENROLLMENT (date) _____
CHANGE IN ENROLLMENT (date) _____

- TYPE OF CHANGE** (check all that apply)
- Name Marriage
 - Address Divorce
 - Delete a Dependent Birth
 - Add a Dependent Beneficiary
 - Other _____

DEPENDENT COVERAGE (If more space is needed, attach extra copies or pages.)

Spouse (last, first, middle initial) _____
 F M Date of Birth (mm/dd/yyyy) ___/___/_____

Child (last, first, middle initial) _____
 F M F/T Student Yes No Date of Birth (mm/dd/yyyy) ___/___/_____

Child (last, first, middle initial) _____
 F M F/T Student Yes No Date of Birth (mm/dd/yyyy) ___/___/_____

Child (last, first, middle initial) _____
 F M F/T Student Yes No Date of Birth (mm/dd/yyyy) ___/___/_____

LIFE/LTD BENEFICIARY

Primary (last, first, middle initial) _____ Relationship _____
Primary (last, first, middle initial) _____ Relationship _____
Contingent (last, first, middle initial) _____ Relationship _____

GMRP: Amount of Coverage Requested \$ _____

LTD: I certify that I am not currently disabled and that I am performing all duties required for my job on a full time basis.

CONTRIBUTORY BENEFITS ONLY

- Request to Participate I hereby request to participate in the insurance program. I agree to contribute as required.
- Waiver of Insurance I do not wish to participate in the insurance program. I understand that if I wish to participate at a later date, my benefits may be denied or reduced.

The information provided above is true and complete to the best of my knowledge and belief.

SIGNATURE _____ DATE _____

NOTICE (not applicable to life insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.