Dental Health Services

UTU Enrollment/Change Form

Effective Date _____

Dentist Number _____

Use Office Numbers beginning with CA when making your dental office selection.

Employee information

Name _____ SSN _____

Address _____ Gender _____

City _____ State _____ Zip Code _____

Phone Number _____ Email _____

Date of Hire _____ Date of Birth _____

Employee Type ☐ Full Time ☐ Part Time ☐ Retiree ☐ COBRA

Company information

Company Name UTU - MTA Trust Fund

Address 15999 Cypress Avenue

City Irwindale State CA Zip Code 91706

Please check reason for application:

___ Address Change ___ Name Change ___ Dental Office Change ___ Employee Status Change

___ Reinstate Coverage ___ Terminate Coverage ___ COBRA Enrollment

Dependent information

	Last Name	First Name	M.I.	Gender	Date of Birth	Relationship
☐ Add ☐ Delete						
☐ Add ☐ Delete						
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I hereby request coverage and authorize payroll deductions (if applicable) from my earnings for any contributions required for a minimum of one year. Authorization is granted to release my patient history to Dental Health Services, consulting health professional, or other entity designated or approved by Dental Health Services for the purpose of certifying, purchasing, providing, evaluating, or administering benefits. This authorization remains in effect until revoked by me in writing.

Employee signature Date

Trust Fund Use Only

Authorized by _____ Group Number _____ Date _____