Dental Health Services

# SMART-MTA 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 SMART- 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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| ☐ Add ☐ Delete | | | | | | |

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 _____