# SMART - MTA TRUST FUND - 2022
# ENROLLMENT CARD

**PLEASE PRINT**

| *FOR OFFICE USE* |
|---|
| HEALTH PLAN: _____ |
| DENTAL PLAN: _____ |
| EFFECTIVE DATE: _____ |

NAME _____
LAST FIRST MI

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: ☐ SMART-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 SMART-MTA TRUST FUND.

SIGNATURE _____ TODAY'S DATE _____

| **DEPENDENTS:** | LAST NAME | FIRST | MI | M | F | **BIRTH DATE** MONTH / DAY / YEAR | **SOCIAL SECURITY** (REQUIRED AS OF 2012) |
|---|---|---|---|---|---|---|---|
| SPOUSE | | | | | | / / | - - |
| CHILD | | | | | | / / | - - |
| CHILD | | | | | | / / | - - |
| CHILD | | | | | | / / | - - |
| CHILD | | | | | | / / | - - |
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