SMART - MTA TRUST FUND - 2023
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 ____________ HIRE DATE ____________

I CHOOSE FOR MY HEALTH CARE: ☐ ANTHEM PLAN (PPO) ☐ UNITEDHEALTHCARE Harmony (HMO)
☐ KAISER (HMO) ☐ UNITEDHEALTHCARE Value (HMO)

I CHOOSE FOR MY DENTAL: ☐ DELTA DENTAL (PPO) **FULL TIME ONLY** ☐ DENTAL HEALTH SERVICES

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 ______________________________ DATE ____________

EMAIL ADDRESS : ______________________________

DEPENDENTS:

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

BENEFICARY		SOCIAL SECURITY	PERCENTAGE
NAME	PHONE #	- -	
NAME	PHONE #	- -	

www.smart-mtatrustfund.com