SMART - MTA TRUST FUND - 2024
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 _____ HIRE DATE _____ PT _____ FT _____

MEDICAL PLAN SELECTED
- ☐ ANTHEM PLAN (PPO)
- ☐ KAISER (HMO)
- ☐ UNITEDHEALTHCARE Harmony (HMO)
- ☐ UNITEDHEALTHCARE Value (HMO)

DENTAL PLAN SELECTED
- ☐ DELTA DENTAL (PPO)
- ☐ 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: _____

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 #	- -	