Kingston Trust Fund Compliance Office
416 Creekstone Rdg
Woodstock, GA 30188
Phone: 844-583-3863 Fax: 770-874-1097
Please email form to: enrollment@ktftrustfund.com

THE KINGSTON TRUST FUND PLAN

MEDICAL AND DENTAL ENROLLMENT/CHANGE FORM

(Please Print)

Internal Use:
Subgroup: _____
DOH: _____
Eff Date: _____
Family Eff Date: _____

PRIMARY MEMBER INFORMATION

Legal Last:	Legal First:	Legal Middle:	Marital Status (circle one): Single / Mar / Sep / Div / Wid
Personal Email Address:			Birth Date: / /
Employment Status (circle one): Teacher / ESP / Other Active / Retiree / Medicare			Sex: ❑ M ❑ F
Mailing Address:		Social Security No.:	Medicare ID No.:
City/Village/Hamlet:	State:	ZIP Code:	Home Phone No.: ( ) / Cell Phone No.: ( )

CHOOSE ONE: ❑ New Enrollment ❑ Open Enrollment ❑ Change ❑ Reinstate

TYPE OF CHANGE:
❑ New Hire ❑ Retirement ❑ Marriage ❑ Loss of Coverage
❑ Add Dependent ❑ Cancel Dependent ❑ Birth ❑ Adoption
❑ Other Insurance ❑ Address Change ❑ Divorce ❑ Change in Student Status
❑ Other (specify):

MEDICAL: ❑ Individual ❑ EE/Spouse ❑ EE/Child(ren) ❑ Family **AND/OR** **DENTAL**: ❑ Individual ❑ EE/Spouse ❑ EE/Child(ren) ❑ Family

SPOUSE AND DEPENDENT INFORMATION

****MARRIAGE CERTIFICATE AND DEPENDENT BIRTH CERTIFICATE(S) ARE REQUIRED****

	Legal First:	Middle:	Relationship (circle one):	Birth Date:	Sex:
1. Legal Last:			Spouse / Child / Other	/ /	❑ M ❑ F
Social Security No.:					
2. Legal Last:	Legal First:	Middle:	Relationship (circle one):	Birth Date:	Sex:
Social Security No.:			Child / Other	/ /	❑ M ❑ F
3. Legal Last:	Legal First:	Middle:	Relationship (circle one):	Birth Date:	Sex:
Social Security No.:			Child / Other	/ /	❑ M ❑ F
4. Legal Last:	Legal First:	Middle:	Relationship (circle one):	Birth Date:	Sex:
Social Security No.:			Child / Other	/ /	❑ M ❑ F

OTHER COVERAGE – *MUST COMPLETE* – PLEASE USE BACK FOR ADDITIONAL INFORMATION

Is/Are your spouse/dependent(s) actively at work? ❑ No ❑ Yes Does/Do spouse/dependent(s) have other ❑ Medical or ❑ Dental coverage? ❑ None Spouse's Medicare ID No.: _____	Other Coverage: ❑ Individual ❑ Family	Medical Policy Co. & No.:	Dental Policy Co. & No.:
		Other Medical Effective Date:	Other Dental Effective Date:

Other Coverage applies to which Dependent(s) above? (Please circle all applicable.) **1. / 2. / 3. / 4. (On Back) 5. / 6. / 7.**

Are your dependents from a prior marriage/relationship? Please explain who must cover dependent(s) and **provide copy of divorce papers.**

Are you, your spouse, or any of your dependents disabled? Please explain and give Medicare information here.

I certify that the information provided in this application is true and correct to the best of my knowledge. I understand that any false statements could result in termination of coverage for me and any dependents. I acknowledge it is my responsibility to notify the Kingston Trust Fund within 31 days of any status change, including the date a covered family member no longer qualifies as an eligible dependent. I also understand that I or any Medicare eligible spouse or dependent is required to enroll in Medicare Part A and B once the individual is no longer covered for health coverage as an employee or a dependent of an employee who is actively employed.

Member Signature *Date*