Kingston Trust Fund
PO Box 4461
Kingston, NY 12402-4461
Phone: 845-338-5422 Fax: 845-338-0391

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

THE KINGSTON TRUST FUND PLAN

MEDICAL AND DENTAL ENROLLMENT FORM
(FILLABLE)

PRIMARY MEMBER INFORMATION

Legal Last:	Legal First:	Legal Middle:	Marital Status (choose one): Select
Email Address:			Birth Date: / Sex: Select
Employment Status (choose one): Select			
Mailing Address:		Social Security No.:	Medicare ID No.:
City/Village/Hamlet:	State:	ZIP Code:	Home Phone No.: / Cell Phone No.:
TYPE OF ENROLLMENT: Select		TYPE OF ENROLLMENT CHANGE: Select	

MEDICAL COVERAGE TYPE: Select

AND/OR DENTAL COVERAGE TYPE: Select

SPOUSE AND DEPENDENT INFORMATION
(If necessary, please use a second form to add additional dependents.)

	Last:	First:	Middle:	Relationship (choose one):	Birth Date:	Sex:
1.				Select		Select
	Social Security No.:					
2.				Select		Select
	Social Security No.:					
3.				Select		Select
	Social Security No.:					
4.				Select		Select
	Social Security No.:					

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

Is/Are your spouse/dependent(s) actively at work? Select	Other Medical: Select	Medical Policy Co. & No.:	Dental Policy Co. & No.:
Does/Do spouse/dependent(s) have other coverage? Select	Other Dental: Select	Other Medical Effective Date:	Other Dental Effective Date:
Spouse's Medicare ID No.:			

Other Coverage applies to which Dependent(s) above? (Please check all applicable dependents.) ☐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 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*