



Kingston Trust Fund Compliance Office
416 Creekstone Rdg
Woodstock, GA 30188
Phone: 844-583-3863 Fax: 770-874-1097
Please email form to: enrollment@ktfftrustfund.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: _____ <input type="checkbox"/> M <input type="checkbox"/> F	
Mailing Address:			Social Security No.:		Medicare ID No.:
City/Village/Hamlet:		State:	ZIP Code:	Home Phone No.: ()	Cell Phone No.: ()
CHOOSE ONE: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Reinstate					
TYPE OF CHANGE: <input type="checkbox"/> New Hire <input type="checkbox"/> Retirement <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Add Dependent <input type="checkbox"/> Cancel Dependent <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other Insurance <input type="checkbox"/> Address Change <input type="checkbox"/> Divorce <input type="checkbox"/> Change in Student Status <input type="checkbox"/> Other (specify): _____					
MEDICAL: <input type="checkbox"/> Individual <input type="checkbox"/> EE/Spouse <input type="checkbox"/> EE/Child(ren) <input type="checkbox"/> Family AND/OR DENTAL: <input type="checkbox"/> Individual <input type="checkbox"/> EE/Spouse <input type="checkbox"/> EE/Child(ren) <input type="checkbox"/> Family					
SPOUSE AND DEPENDENT INFORMATION (If necessary, please use back to add additional dependents.)					
1. Legal Last:		Legal First:		Middle:	Relationship (circle one):
Social Security No.:					Spouse / Child / Other
2. Legal Last:		Legal First:		Middle:	Relationship (circle one):
Social Security No.:					Child / Other
3. Legal Last:		Legal First:		Middle:	Relationship (circle one):
Social Security No.:					Child / Other
4. Legal Last:		Legal First:		Middle:	Relationship (circle one):
Social Security No.:					Child / Other
OTHER COVERAGE – MUST COMPLETE – PLEASE USE BACK FOR ADDITIONAL INFORMATION					
Is/Are your spouse/dependent(s) actively at work? <input type="checkbox"/> No <input type="checkbox"/> Yes		Other Coverage:		Medical Policy Co. & No.:	
Does/Do spouse/dependent(s) have other <input type="checkbox"/> Medical or <input type="checkbox"/> Dental coverage? <input type="checkbox"/> None		<input type="checkbox"/> Individual <input type="checkbox"/> Family		Dental Policy Co. & No.:	
Spouse's Medicare ID 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 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 _____		