Kingston Trust Fund
PO Box 4461
Kingston, NY 12402-4461
Phone: 845-338-5422
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THE KINGSTON TRUST FUND PLAN

MEDICAL AND DENTAL ENROLLMENT FORM

(Please Print)

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

PRIMARY MEMBER INFORMATION

Legal Last:	Legal First:	Legal Middle:	Marital Status (circle one): Single / Mar / Div / Sep / Wid
Email Address:			Birth Date: / / — Sex: ❑ M ❑ F
Employment Status (circle one): Teacher / ESP / Other Active / Retiree / Medicare			
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

(If necessary, please use back to add additional dependents.)

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