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
(FILLABLE)

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

PRIMARY MEMBER INFORMATION

Legal Last:	Legal First:	Legal Middle:	Marital Status (choose one): Select
Personal 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
****MARRIAGE CERTIFICATE AND DEPENDENT BIRTH CERTIFICATE(S) ARE REQUIRED****

	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*

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

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*