customersupport@tpaexchange.com Fax: 866-223-6521

TVTA BENEFIT TRUST FUND ENROLLMENT / CHANGE REQUEST FORM

☐ **New Enrollment** ☐ **Termination** **Termination Date:_____** ☐ **COBRA EVENT**	☐ **Change :** ☐Add Dependent (Marriage, Newborn, Adoption, etc.) ☐Terminate Dependent ☐Divorced ☐Married ☐New Married Name ☐ Resume Maiden Name ☐ Change Address/DOB/Tel ☐ Medicare Eligible ☐ Reduction of Hours **Date of occurrence/effective date of change**:_____ **Benefits Effective Date:_____**

Name			Date of hire:
Address:	City	State	Zip
SSN	Date of Birth	Email Address:	
Single: ☐ Married: ☐ Domestic Partner: ☐		Home Phone	

Teacher: ☐ Paraprofessional: ☐ Teaching Assistant: ☐

Is your Spouse or Domestic Partner employed? Yes ☐ No ☐

Is Spouse or Domestic Partner covered by any Dental Plan? Yes ☐ No ☐	Plan Name
Is Spouse or Domestic Partner covered by any Vision Plan? Yes ☐ No ☐	Plan Name

List below name(s) of spouse / domestic partner and unmarried child(ren) under 26 years of age. Unmarried dependent children over the age of 19 are eligible for benefits only if they are fulltime students.
(Please submit proof of marriage, dependent birth certificate, domestic partner registration, and/or full time student status for dependent over age 19, as applicable each semester

	Name	*SSN*	*Address*	DOB	Gender
Spouse/DP					M☐ F☐
Child					M☐ F☐
Child					M☐ F☐
Child					M☐ F☐
Child					M☐ F☐
Child					M☐ F☐

STEP 2: Life Insurance **Decline ☐ I wish coverage (if offered) ☐** **$20,000 Policy☐** **$50,000 Policy☐** **I**

Beneficiary: Please specify below

Primary Beneficiary

Name	**Address**	**DOB**	**Relationship**	**Percentage**

Secondary Beneficiary

Name	**Address**	**DOB**	**Relationship**	**Percentage**

Tertiary Beneficiary

Name	**Address**	**DOB**	**Relationship**	**Percentage**

Step 3: Choose your coverage:

DENTAL:

I wish coverage (if offered) **Yes☐** **No☐** **I wish to cover:** **Self☐** **Self and Spouse☐** **Self and Child(ren)☐** **Family☐**

If Declined Coverage, please state reason here: _____

VISION:

I wish coverage (if offered) **Yes☐** **No☐** **I wish to cover:** **Self☐** **Self and Spouse☐** **Self and Child(ren)☐** **Family☐**

If Declined Coverage, please state reason here: _____

STEP 6 Signature

I certify that the information supplied by me is true and correct. I understand that it is solely my responsibility to timely notify, in advance where possible, my employer, union, or health plan administrator of any changes that may affect coverage of myself or of any of my enrolled dependents. I further understand that my failure to so timely notify those of any change in status that would affect coverage shall render me solely responsible for reimbursing the Fund for any claims paid on behalf of an ineligible enrollee or dependent, including myself. I further understand that any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims.

MEMBER ELECTRONIC SIGNATURE (PLEASE PRINT)		Date