



DUAL OPTION ENROLLMENT FORM

EMPLOYER INFORMATION			
Employer's Name Transport Workers Union, Local 100			
Group Number GG-668 M04/P04		Effective Date	
MEMBER INFORMATION			
BSC# (ID#)		SSN	
Last Name		First Name	M.I.
Address		City	State
			Zip Code
Home Phone	Email Address		Gender <input type="checkbox"/> M <input type="checkbox"/> F
			D.O.B.
Other Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other plan (if applicable)		
MEMBER MARITAL STATUS			
<input type="checkbox"/> Single	<input type="checkbox"/> Domestic Partners	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced/Widow
DEPENDENTS TO BE COVERED - SPOUSE/DOMESTIC PARTNER AND DEPENDENT CHILDREN (COVERED UP TO THEIR 26TH BIRTHDAY).			
Dependent (Last Name, First Name)	D.O.B.	Relationship to Member	Reason and Date of Occurrence
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Dependent (Last Name, First Name)	D.O.B.	Relationship to Member	Reason and Date of Occurrence
SELECT ONE PLAN			
<input type="checkbox"/> Managed Care Plan*		<input type="checkbox"/> PPO Plan	
*DENTAL SELECTION-PLEASE CHOOSE ONE PRIMARY CARE DENTIST (PCD) FROM THE MANAGED CARE - COMPREHENSIVE PANEL (ONE PCD PER FAMILY).			
A second provider option has been provided in the event your first choice is not accepting new patients or no longer on the panel.			
Dental Provider/Office Name - Selection 1		Provider ID Number	
Dental Provider/Office Name - Selection 2		Provider ID Number	
By signing below, I affirm that I am employed by the above-referenced employer/group. I understand that I am responsible for the payment of monthly premium due to Dentcare Delivery Systems, Inc. for dental coverage.			
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any act material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.			
Member Signature		Date	

Return completed form to:

TRANSPORT WORKERS UNION, LOCAL 100
 195 Montague Street
 Brooklyn, NY 11201

Email: member.services@twulocal100.org -or- Fax: 347-643-8063