EmblemHealth®

Dental Enrollment Form

EMPLOYER INFORMATION

Group Name (Group Number)	Effective Date (Required)
☐ TWU Local 100 (1141809 1001) ☐ Liberty Lines/Westchester (1141809 1003)	

MEMBER INFORMATION

BSC# (ID#)	Social Security Number	
Last Name	First Name	M.I.
Address		Apt
City	State	ZIP Code

Home Phone	Email Address	Gender	D.O.B.
Other Dental Coverage ☐ Yes ☐ No	Name of other plan (if applicable)		

MEMBER MARITAL STATUS

☐ Single ☐ Domestic Partner ☐ Married ☐ Divorced/Widow

DEPENDENTS TO BE COVERED – Spouse/Domestic Partner and Dependent Children (covered up to their 26th birthday).

Dependent (Last Name, First Name)	Date of Birth (DOB)	Gender	Social Security Number (optional)	Relationship to Member
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In order for TWU Local 100 to complete the processing of your benefits, you must provide us with copies of the following documents:

- Marriage certificate for spouse
- Social Security cards for all dependents
- Birth certificate for all dependents
- Adoption/Legal Guardianship papers for dependent children

By signing below, I affirm that I am employed by the above-referenced employer/group. I understand that my employer is responsible for the payment of monthly premium due to EmblemHealth Plan, 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 a thousand dollars and stated value of the claim for each violation.

Member Signature	Date

Return completed form to:

Transport Workers Union, Local 100
149 Pierrepont Street, Room 1.100
Brooklyn, N.Y 11201

Email: **member.services@twulocal100.org** -or- Fax: **347-916-0629**

PRINT RESET