HARRISON ASSOCIATION OF TEACHERS BENEFIT TRUST FUND

ENROLLMENT (AND CHANGE OF ENROLLMENT) FORM

THE HARRISON ASSOCIATION OF TEACHERS BENEFIT TRUST FUND (HATBTF) IS THE PROVIDER OF THE FOLLOWING BENEFITS:

DENTAL PLAN – Employee contribution required
VISION BENEFIT PLAN – no cost
FLEXIBLE BENEFIT PROGRAM – no cost
LONG TERM DISABILITY PROGRAM – no cost
GROUP LIFE INSURANCE PROGRAM – no cost

Please complete the following information as well as select whether you wish to enroll in Dental coverage. All payments will be deducted through payroll.

______________________________ ______________________________ ____________________

Name of Employee *(please print)* **School/Building Assignment** **Employment Start Date**

Employee Group: *Teacher/HAT* [ ] *Administration/HAA* [ ] *District Office/Non-affiliated Administration* [ ]

Dental Option: *Yes* [ ] *No* [ ] **Dental Option Plan**: *Family ($200.00)* [ ] *Single*: *($50.00)* [ ]

EMPLOYEE INFORMATION

Name: ______________________ Birth Date: ______________ Social Security Number: ________- ______ - _______

Home Address: ______________________________ City: __________________ State: _______ Zip: ___________

Home Phone: ______________________ Cell Phone: ______________________

DEPENDENT INFORMATION

Spouse: ______________________ Birth Date: ______________

Spouse's Employer: ____

Does your spouse have Dental Coverage? *Yes* [ ] *No* [ ]

If so, with what Dental Plan/Company? ______________________________________

Please list all eligible dependents ***other than*** spouse:

Name	***Date of Birth***
1. ______________________	______________
2. ______________________	______________
3. ______________________	______________
4. ______________________	______________
5. ______________________	______________

EMPLOYEE SIGNATURE ACKNOWLEDGING THAT THE ABOVE INFORMATION PROVIDED TO THE HATBTF IS ACCURATE

Signature: __________________________ Date: ______________

TO BE COMPLETED BY A HATBTF REPRESENTATIVE

Date of Employment: ______________

Effective Date of Enrollment: ____________

Trust Fund Representative (Name): ______________________________

Trust Fund Representative (Signature): ______________________________

Enrollment Type:
[ ] New
[ ] Change
[ ] Terminate
[ ] Active to Retiree

Information Validated and Changes Acceptable – PGP Please Process ASAP
[ ] Yes [ ] No