Plans Underwritten by: Dentcare®

Plans Administered by: healthplex®

DUAL OPTION ENROLLMENT FORM

Employer Information

Employer's Name: Transport Workers Union, Local 100

Group Number: GG-668 M01/M02/P01/P02

Effective Date:

Member Information

BSC# (ID#)	SSN		
Last Name	First Name	M.I.	
Address	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 Partners ☐ Married ☐ 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

Select One Plan

☐ Managed Care Plan* ☐ 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 my employer is 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 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