Mt. Pleasant Teachers Association

c/o Insurance Programmers, Inc.
PO Box 5817
Wallingford CT 06492
Phone 1-800-827-1703
Fax 1-203-284-8656

Dental & Vision Enrollment / Change Form

Effective Date: _____

This is a _____ New Enrollment _____ Change to an Existing Enrollment

EMPLOYEE

First Name_____ Last Name _____
Address: _____
City _____ State ____ Zip Code _____
Social Security # _____
Date of Birth: _____ / _____ /_____ Sex: ____ M ____ F
Employment Date: _____ Home Phone # _____
Marital Status:
Single ____ Married ____ Widowed ____
Divorced ____ Separated ____

Are you covered under any other Dental Plan? _____ Vision?
If so, please name plan: _____

SPOUSE

First Name_____ Last Name_____
Social Security # _____
Date of Birth: _____ / _____ /_____ Sex: ____ M ____ F

Is your spouse employed? _____
If so, where?_____

Does your spouse have other Dental coverage? _____ Vision? _____

Are your dependent children covered under your
spouse's or any other Dental plan?_____Vision? ____

DEPENDENT CHILDREN

First Name & Last Name	Sex	Date of Birth	Social Security #	F T Student?	If so, where?
		____/ ____/ ____			
		____/ ____/ ____			
		____/ ____/ ____			
		____/ ____/ ____			
		____/ ____/ ____			
		____/ ____/ ____			

Signature _____ Date: _____
The information provided is true to the best of my knowledge.