VCTA BENEFIT FUND REGISTRATION FORM

This form is to be used to register and update membership eligibility information for our self-funded Dental/Optical Benefit Program. In order to avoid any unnecessary delays in the payment of your claim, please complete the necessary information and return the form ASAP to Marie Scott in Human Resources.

_____

Social Security Number Date Employed

_____

Last Name First Name Birth Date

_____

Street Address City State Zip

_____

School Work Phone Number Home Phone Number

_____

Are you covered for dental benefits under another Plan? (If yes, name of Plan)

_____

Spouse's Name Birth Date Social Security Number

Is spouse employed?_____ If Yes, Name of Employer _____

_____

Street Address City State Zip Work Number

Is spouse covered by another plan? Yes__No__Are dependents covered under this plan Yes__No__

_____

Name of Spouse's Dental Insurance Plan Policy/Plan Number

DEPENDENT INFORMATION - PLEASE LIST ALL DEPENDENTS

NAME	DOB	FULL-TIME STUDENT*	SCHOOL	SS#
_____	__/__/__	Yes__No___	_____	
_____	__/__/__	Yes__No__	_____	
_____	__/__/__	Yes__No__	_____	
_____	__/__/__	Yes__No__	_____	
_____	__/__/__	Yes__No__	_____	

*If dependent child is 19 or older and is a full-time student, please provide proper verification

SIGNATURE:_____DATE:_____

FOR OFFICE USE ONLY: Eligibility Date:_____Status:_____Remark:_____