DENTAL PLANS
LODGE 447 FRINGE BENEFIT TRUST FUND

140 Sylvan Avenue, Suite 303 • Englewood Cliffs, NJ 07632 • (201) 592-6800

PRINT ALL INFORMATION Mr. Mrs. Miss. Last Name	First Name	Middle Initial
Home Address Street and Number	City & State	Zip Code
Name of Employer / Email Address	Date Employed	SEX (M) ☐ (F) ☐
Home Telephone Number / Cell Phone Number	Social Security Number	Date of Birth Month Day Year
Marital Status (Check One) ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated		

LIST ALL DEPENDENT INFORMATION BELOW.

· Refer to the Summary Plan Description for definitions of Spouse and Eligible Dependents.

Signature of Participant _____ **Date** _____

Dependents for coverage under the Dental and Optical Plans
(submit a copy of marriage certificate and/or birth certificate(s) for dependent children)

LIST IN ORDER OF AGE - OLDEST FIRST			CHECK RELATIONSHIP			DATE OF BIRTH			DISABLED
FIRST NAME	LAST NAME (IF DIFFERENT FROM PARTICIPANT)	SOCIAL SECURITY NUMBER	SPOUSE	SON	DAUGHTER	MONTH	DAY	YEAR	YES / NO
			☐	☐	☐				☐ YES ☐ NO
			☐	☐	☐				☐ YES ☐ NO
			☐	☐	☐				☐ YES ☐ NO
			☐	☐	☐				☐ YES ☐ NO
			☐	☐	☐				☐ YES ☐ NO
			☐	☐	☐				☐ YES ☐ NO
			☐	☐	☐				☐ YES ☐ NO