

## DENTAL AND OPTICAL PLANS LODGE 447 FRINGE BENEFIT TRUST FUND

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

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

LIST ALL DEPENDENT INFORMATION BELOW.

 $\cdot$  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