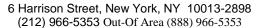
## ENROLLMENT APPLICATION

## **CWA LOCAL 1180 BENEFITS FUNDS**

## SCHEDULED DENTAL BENEFIT PLAN

## **ENROLLMENT FORM**



Retired

Active



1				2. SSN	or ID#					
Last Name		First Name	MI							
3. Home Address										
City		State	ZIP		4	Hom	e Ph	one	No	).
5. Date of Birth	/	I	6. Ge	ender: I	F∏ М					
<u> </u>	DD/MM/YYY	' <u> </u>	0. 0.			ш				
7. Other Dental C	overage				Group	o # _				
8. Marital Status:	Single	Married [	Do	mestic Par	rtnership					
Email Address:										
·		Insurance Carrie		JR.		\ <u> </u>				
Spouse's/Dome 10. List below the Scheduled Denta	names of you	ur spouse/partner	and depen		ole for de ge/23 yrs	ntal b	energe if	its uul-t	ind ime	er the
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NOTE: Be sure to mail with the proper postage. Your Annual Open Enrollment Application must be received by the Fund Office no later than the stated deadline

