Jefferson Federation of Teachers
HEALTH AND WELFARE FUND

2540 Severn Avenue, Suite 302, Metairie LA 70002
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Website: www.jfthw.org Email: info@jfthw.org

Dental and Vision Plans -- Enrollment Form or Waiver of Coverage

DENTAL	VISION
☐ Dental Coverage – Eligible Employee	☐ Vision Coverage – Eligible Employee
☐ Dental Coverage – Dependent(s) Employee authorizes employer to deduct dependent premiums from my salary.	☐ Vision Coverage – Dependent(s) Employee authorizes employer to deduct dependent premiums from my salary.
☐ Waiver of Dental Coverage – Employee has decided not to accept the offer of Dental Coverage.	☐ Waiver of Vision Coverage – Employee has decided not to accept the offer of Vision Coverage.

LAST NAME	FIRST NAME (IN FULL)	MIDDLE NAME (IN FULL)	

HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	E-MAIL

SOCIAL SECURITY NUMBER	JPPSS EMPLOYEE NO.	GENDER	DATE OF BIRTH	MARRIED/SINGLE DIVORCED/WIDOWED (Circle one)

DEPENDENT'S FULL NAME	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP & DEPENDENT TYPE Check all that apply	
			☐ Legally Married ☐ Dependent Child	☐ Legal Guardianship ☐ Court-Ordered (QMCSO) ☐ Dependent up to age 26 ☐ Disabled Child over age 26
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Declaration: By signing this Enrollment Form, I attest and confirm that the above listed Dependents qualify as Eligible Dependents under the Plan. I hereby certify that the information I am submitting is true and accurate to the best of my knowledge. I understand that knowingly providing false or misleading information on this Form may result in disciplinary action up to and including termination of coverage. I also understand that if I present false information resulting in the enrollment of ineligible Dependents, I am responsible for repaying any claims paid by the Plan, and any premium payments made by me will not be refunded. The Fund may request additional information or documents to verify Dependent Eligibility status.

SIGNATURE:____**DATE:**________________________