2024 Enrollment Form

for ATU LOCAL 726 BENEFITS FUND

Your Information *(Please Print)*			
First Name:		Last Name:	
Street Address:			
City:	State:	Zip Code:	Gender: ☐ F ☐ M
Date of Birth (MM/DD/YY):	Social Security Number (XXX-XX-XXXX):	BSC #	
Email Address:	Phone #:	Hire Date:	

New Hires: Your Benefits will be effective the first of the month after 90 days of employment.

You and your family members that you list below will automatically be enrolled in the Amalgamated Basic Life Insurance ($75,000 coverage for the employee only) and GVS (Vision Benefits) AT NO COST TO YOU.

DEPENDENT INFORMATION (Dependents are eligible until the end of the month of their 26th birthday.)

	First Name	Last Name	Gender (M/F)	Social Security Number	Date of Birth (MM/DD/YY)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

_____ –

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First Name: Last Name:

DENTAL INSURANCE

You may choose the Healthplex DMO, Cigna Low Option DMO, Cigna High Option DMO or Healthplex PPO plan. If you participate in the Cigna High Option DMO or Healthplex PPO Dental Plan, you will be charged each month on your Credit Card, Debit Card or Checking Account. Please choose your Dental election and complete the information below for payment if you want to participate in the Cigna High Option DMO or Healthplex PPO Plan.

- ☐ HEALTHPLEX (DMO) - **$0.00**
- ☐ CIGNA LOW OPTION (DHMO) - **$0.00**
- ☐ CIGNA HIGH OPTION (DHMO) - **$19.50 for entire family**
- ☐ HEALTHPLEX PPO OPTION (You do not need to choose a Dentist) – **EE $24.00, EE+1 $69.00, FAM $111.25**
- ☐ GHI Dental (If you are enrolled in the Aetna CPOS II High Option Medical Plan) - **$0.00**

DMO DENTIST CODE: _____

(If you do not choose a Dentist, one will be assigned to you and then you can change it at a later date. To find a dentist, see the contact info below.)

MONTHLY PAYMENT INFORMATION

(You must pay with VISA, MasterCard, Discover, American Express, Debit Card or Automatic Withdrawal from Checking Account. Your payment is charged on the 28th of each month under the name EXTENSIVE BENEFITS – UNION INSURANCE.)

Account Name: (First)_____ (Last)_____

☐ **Credit or Debit Card Number:** **Expiration Date:**

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ___ ___ - ___ ___

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☐ **Checking Account:** ***Bank Name:*** _____

_____ _____

Routing Number (9 digits) *Account Number*

I hereby authorize Extensive Benefits to charge Dental insurance premiums to my credit/debit card indicated in this authorization form. This payment is for the dental insurance monthly premiums. I certify that I am an authorized user of this credit/debit card and that by signing this document, I am accepting all the responsibility for these transactions to ensure full payment until the termination of such benefits. I will inform you immediately if use of this card is no longer valid.

Your Signature: Date:

RETURN THIS FORM TO:
Email: ATU726C@aol.com
Fax: 718-967-8932
Mail: ATU Local 726
3952 Amboy Road
Staten Island, NY 10308

If you have any questions regarding the coverage options, please call 888-416-4211 or email your questions to info@extensivebenefits.com

FOR ADDITIONAL INFORMATION:	Vendor	Phone Number
Billing and Eligibility Questions regarding **Dental, Vision or Life Insurance and COBRA coverage**	Extensive Benefits	888-416-4211
Eligibility Questions regarding **Medical Insurance** or other programs	ATU Local 726 Benefits Fund	718-967-8931
CIGNA Dental – Questions regarding plan design, claims or choosing/locating a provider	CIGNA	800-244-6224
HEALTHPLEX Dental – Questions regarding plan design, claims or choosing/locating a provider	HEALTHPLEX	800-468-0600
GVS Vision – Questions regarding plan design, claims or locating a provider	GVS	855-653-0586
Amalgamated Life – Questions regarding plan design or claims. ***To file a Life claim, please contact the Local at 718-967-8931.***	Amalgamated Life	866-975-4089