

## **IMPORTANT INFORMATION**

No one employed as of September 1, 2010 will be permitted to activate spouse or dependent coverage for the 2010-2011 year after September 24, 2010. There will be no exceptions.

It will be your responsibility to check your October 15, 2010 paycheck stub to ensure that the proper amount is being deducted from your paycheck for Dependent Dental Coverage. If the deduction on the October 15, 2010 paycheck for dependent coverage is not correct, you must notify the Fund within 3 business days. After that, we cannot make any changes to add dependents that you thought were covered.

Reminder Dependent children of eligible employees are covered from the age of ten (10) days until the September 30<sup>th</sup> next occurring after their nineteenth (19<sup>th</sup>) Birthday, or until the September 30<sup>th</sup> next occurring after their twenty-fifth (25<sup>th</sup>) Birthday, if the dependent child is a full-time student at an accredited college or university.

### Coordination of Benefits:

If a spouse or dependent is also covered by another dental plan, then the benefits of the F.U.S.E. Welfare Fund plan may be reduced, so that for any individual procedure, not more than 100% of the reasonable and customary amount will be paid by all such plans .

### 2010-2011 Dependent Enrollment Form:

This form must be signed, dated and delivered to the FUSE office.

### Rates for 2010-2011

Spouse : \$443.60 (annual)

Each Dependent Child: \$239.65 (annual)

NEW ROCHELLE F.U.S.E. WELFARE FUND  
**2010-2011 DEPENDENT ENROLLMENT FORM**

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**EMPLOYEE INFORMATION (PLEASE PRINT)**

\_\_\_\_\_  
Last Name                      First Name                      M.I.                      Social Security #                      School / Location

\_\_\_\_\_  
ADDRESS: No. and Street                      City                      State                      Zip

\_\_\_\_\_  
Date of Birth                      Telephone No.                      Date

Marital Status:     Single             Married             Divorced             Legally Separated

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**DEPENDENTS' INFORMATION (PLEASE PRINT)**

Please only list information for a spouse and/or dependents that you wish to have covered.

**All information (including Social Security numbers) must be supplied before coverage for spouse or dependents can be activated.**

**SPOUSE**

\_\_\_\_\_  
Last Name                      First Name                      M.I.                      Social Security #                      Date of Birth

Is spouse covered by another plan?     Yes     No    If yes, please name other plan \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

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**DEPENDENT CHILDREN (PLEASE PRINT)**

**LEGALLY ELIGIBLE CHILDREN TO BE COVERED:**

<u>Name</u>	<u>Social Security #</u>	<u>Relationship</u>	<u>Date of Birth</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Are dependent children covered by another plan?     Yes     No

If yes, please name other plan \_\_\_\_\_

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By signing this enrollment form, you are acknowledging that you understand that: 1) funds will be deducted from your paychecks during the months of October through and including June; 2) that this is an opt-out plan. Funds will be deducted every year until you notify us of any additions or deletions.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_