MILA MANAGED HEALTH CARE TRUST FUND

INSTRUCTIONS: **Please fill out the entire form using BLACK ink.** Please write neatly using capital letters. When complete, answer the questions at the bottom of the page and sign your name in the signature box.

EMPLOYEE RECORD

Social Security Number: ___ – ___ – ____ **Birth Date:** __ / __ / ____ (mm/dd/yyyy)

Employee Status: ○ Active ○ Retired ○ Deceased **Sex:** ○ M ○ F **Disabled:** ○ Yes ○ No

First Name: **MI:** **Last Name:**

Address 1:

Address 2:

Marital Status: ○ Single ○ Divorced ○ Married ○ Widowed

City: **State:** **Zip:** **Retirement Date:** __ / __ / ____

Dependent 1

Terminate Coverage?: ☐

Social Security Number: ___ – ___ – ____ **Birth Date:** __ / __ / ____ (mm/dd/yyyy)

Relation: ○ Spouse ○ Child ○ Other **Sex:** ○ M ○ F **Student:** ○ Y ○ N **Disabled:** ○ Y ○ N

First Name: **MI:** **Last Name:**

Dependent 2

Terminate Coverage?: ☐

Social Security Number: ___ – ___ – ____ **Birth Date:** __ / __ / ____ (mm/dd/yyyy)

Relation: ○ Spouse ○ Child ○ Other **Sex:** ○ M ○ F **Student:** ○ Y ○ N **Disabled:** ○ Y ○ N

First Name: **MI:** **Last Name:**

Dependent 3

Terminate Coverage?: ☐

Social Security Number: ___ – ___ – ____ **Birth Date:** __ / __ / ____ (mm/dd/yyyy)

Relation: ○ Spouse ○ Child ○ Other **Sex:** ○ M ○ F **Student:** ○ Y ○ N **Disabled:** ○ Y ○ N

First Name: **MI:** **Last Name:**

Dependent 4

Terminate Coverage?: ☐

Social Security Number: ___ – ___ – ____ **Birth Date:** __ / __ / ____ (mm/dd/yyyy)

Relation: ○ Spouse ○ Child ○ Other **Sex:** ○ M ○ F **Student:** ○ Y ○ N **Disabled:** ○ Y ○ N

First Name: **MI:** **Last Name:**

Dependent 5

Terminate Coverage?: ☐

Social Security Number: ___ – ___ – ____ **Birth Date:** __ / __ / ____ (mm/dd/yyyy)

Relation: ○ Spouse ○ Child ○ Other **Sex:** ○ M ○ F **Student:** ○ Y ○ N **Disabled:** ○ Y ○ N

First Name: **MI:** **Last Name:**

Dependent 6

Terminate Coverage?: ☐

Social Security Number: ___ – ___ – ____ **Birth Date:** __ / __ / ____ (mm/dd/yyyy)

Relation: ○ Spouse ○ Child ○ Other **Sex:** ○ M ○ F **Student:** ○ Y ○ N **Disabled:** ○ Y ○ N

First Name: **MI:** **Last Name:**

Dependent 7

Terminate Coverage?: ☐

Social Security Number: ___ – ___ – ____ **Birth Date:** __ / __ / ____ (mm/dd/yyyy)

Relation: ○ Spouse ○ Child ○ Other **Sex:** ○ M ○ F **Student:** ○ Y ○ N **Disabled:** ○ Y ○ N

First Name: **MI:** **Last Name:**

QUESTIONS

Are you or your dependents covered under another healthcare insurance program or policy OTHER THAN MILA'S CIGNA PLAN? YES ☐ NO ☐

Are you or your dependents entitled to benefits from Medicare? YES ☐ NO ☐ ***(If yes, please send us a photocopy of each Medicare card.)***

Do you access the Internet from home? YES ☐ NO ☐

E-mail address (leave blank if none):

Please return this form to:
MILA, 111 Broadway, 5th Floor, New York, NY 10006

sign here

I verify that the above information is correct.

DATE

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