



Jon Stern and Ron Simon
Administrators

NEW PALTZ UNITED TEACHERS BENEFIT TRUST FUND
Active Member Dental Buy-up/Change and Payroll Deduction
Form

Name: _____ Building (s): _____

Address: _____ City: _____ State: _____ Zip: _____

Personal Email: _____ Telephone: () _____ Cell phone: () _____

Date of Birth: _____ Social Security No.: _____ Marital Status: _____

NPUT TRUST FUND DENTAL PLAN: Dependent children can be covered to age 26.

Dependent change, list below ____ add dependent(s) _____ delete dependent(s)

Do you or your dependents have other dental coverage? ____ yes Carrier name and group number _____

	Last/First Name	Gender M/F	Date of birth	Social Security Number
Spouse				
Child(ren)				

I hereby authorize the NPUT Benefit Trust Fund to arrange, on my behalf, payroll deductions with the New Paltz Central School District in order to deduct from my salary and transmit to the NPUT Benefit Trust Fund a sum as indicated to provide coverage from the date indicated through August 31 or last month worked.

NPUT TRUST FUND DENTAL PLAN.

Dental Plan Premiums 2020 - 2021

____ Employee and Single Dependent – \$34.32 per month – deducted evenly over the remaining payrolls.

(Annual Cost to member \$411.80 pro-rated)

____ Employee and Multiple Dependents – \$75.04 per month – deducted evenly over the remaining payrolls.

(Annual Cost to Member \$900.44 pro-rated)

Effective Date: _____

Signature: _____