



2027 Enrollment Form for ATU LOCAL 726 BENEFITS FUND

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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 #:		New Hire: ☐ Yes ☐ No	

You and your family members that you list below will automatically be enrolled in the Amalgamated Basic Life Insurance (\$100,000 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					
Dependent					

DENTAL INSURANCE

You may choose the Healthplex DMO, Cigna Low Option DMO, Cigna High Option DMO, Healthplex PPO, Metlife, or CGS 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
☐ CPS DENTAL - \$0.00
☐ CIGNA LOW OPTION (DHMO) - \$27.60
☐ CIGNA HIGH OPTION (DHMO) - \$85.00 for entire family
☐ HEALTHPLEX PPO OPTION (You do not need to choose a Dentist) - EE \$30.00, EE+1 \$75.05, FAM \$141.95
☐ MET50 (NY/NJ only) - EE \$0.00, EE+SP \$0.00, EE+CH \$0.00, FAM \$21.25
☐ MET185 (NY/NJ/CA/FL/TX only) - EE \$0.00, EE+SP \$0.00, EE+CH \$0.00, FAM \$21.25
☐ METLIFE PPO LOW - EE \$8.50, EE+SP \$44.65, EE+CH \$48.00, FAM \$93.50
☐ METLIFE PPO HIGH - EE \$32.00, EE+SP \$95.85, EE+CH \$108.70, FAM \$186.75
☐ EMBLEM (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.)



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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 COMPREHENSIVE.)

Account Name: (First) _____ (Last) _____

☐ Credit or Debit Card Number: _____ Expiration Date: _____
MM YY

☐ Checking Account: Bank Name: _____

ROUTING NUMBER ACCOUNT NUMBER CHECK NUMBER

Routing Number (9 digits) Account Number

Please note credit card payments may be subject to an applicable processing fee. Any such fee will be determined based on the payment processing method and applicable requirements

I hereby authorize Comprehensive Healthcare Systems 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
Mail: ATU Local 726
3952 Amboy Road
Staten Island, NY 10308

THIS FORM CANNOT BE EMAILED
FROM THE UNION OFFICE