2018 Direct Reimbursement Dental Plan
Enrollment Form

Plan Sponsor: ***PBA***

Agency_____

Member Name_____

Member Address_____

City, State & Zip_____

Phone #_____ Social Security No.#_____/____/_____

Date of Birth _____ Male __ Female __

Total # to be enrolled in coverage (including you) _____

Dependent Information (if applicable):

Name	Relationship	DOB
Name	Relationship	DOB
Name	Relationship	DOB
Name	Relationship	DOB

_____ _____

Signature **Date**

(Include new dues authorization form with Enrollment Form)

This section to be completed by Sun Coast PBA Benefits Administrator

Received: _____

Date Coverage Begins: _____

Notice to employer and Sun Coast PBA
Authorization for deduction of union dues

Complete and mail or Fax to:
Sun Coast PBA
14141 – 46th St. N. #1205
Clearwater, FL 33762
Phone (727) 532-1722 • Fax (727) 530-4816

I hereby authorize my Employer to deduct from my salary each pay period, my PBA dues, dental or AFLAC dues (if applicable) as certified to the Employer by the Sun Coast PBA.

I understand this authorization is voluntary and I may revoke it at any time by giving my Employer and the Sun Coast PBA thirty (30) days notice in writing.

Date _____ **Print Name** _____

Job Title _____ **Signature** _____

Agency Payroll Number _____ **Agency Name** _____

Office Use Only:

PBA Union Official _____ Date Received _____/_____ Date Sent To Agency

Date Scanned to member file _____