Middletown Works Hourly & Salaried Union
Retirees Health Care Fund
1201 Crawford Street • Middletown, OH 45044
PH: (513) 217-4818 • TOLL FREE: (877) 392-9991 • Fax: (513) 672-9622

DENTAL AND VISION COVERAGE
2024 ENROLLMENT FORM

Use this form ONLY if you wish to CHANGE your enrollment in the Dental/Vision plans for 2024.

Members who choose to newly ENROLL into or OPT-OUT of Dental/Vision benefits for 2024;

should fill out the form below and return to the Fund Office by: 00/00/20XX

Fax: 513-672-9622 Email: mwrmemberservices@wpas-inc.com

Or Mail: 1201 Crawford Street, Middletown, OH 45044

Members who already have Dental/Vision benefits through the Fund will remain eligible in both plans.

Participant Information

(Please print clearly)

Name:_____

Last 4 Digits of Social Security Number: _____ Email Address:_____

Date of Birth: _____ Telephone Number: _____

Address: _____

City/State/Zip: _____

☐ I choose to OPT-OUT or cancel my current Dental/Vision coverage effective January 1, 2024. I understand that I will not be eligible to re-enroll in the coverage until January 1, 2025.

☐ I want to ADD Dental and Vision coverage for myself for a monthly premium payment of $10 for single coverage.

☐ I want to ADD Dental and Vision coverage for myself and/or dependents for a monthly premium payment of $20 for full family coverage. *Please complete the following information.*

Spouse's Name	Gender	Birth Date	Social Security #
Dependent's Name	Gender	Birth Date	Social Security #
Dependent's Name	Gender	Birth Date	Social Security #

Authorization

Participant's Signature: _____ Date: _____