# Port Chester Teachers Association Welfare Trust Fund

**Mail TO: ADMINISTRATIVE SERVICES ONLY, INC.**
**PO BOX 9010**
**LYNBROOK, NY 11563**
**516-396-5500**

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## DECLINATION OF COVERAGE

## DENTAL AND/OR VISION BENEFITS

**Member's Name Last_____ First_____ Middle_____**

**Address:_____**

**City_____ St_____ Zip_____**

**Soc Sec No (last 4)_____ _____ _____ _____ Date of Birth _____**

**This is to acknowledge and certify that I am currently a covered member of the Port Chester Teachers Association Welfare Trust Fund.**

**However, effective upon my signing of this form, I hereby decline and waive further coverage of the following Fund benefits for myself and any of my eligible dependent(s) currently enrolled in such benefits (please place a "check mark" below next to the benefits you wish to decline):**

**____ DENTAL BENEFITS ____ VISION BENEFITS**

**I hereby agree to indemnify and make whole the Port Chester Teachers Association Welfare Trust Fund, its heirs and assigns against any and all liability and/or loss arising out of my request to decline and waive further coverage of these benefits for myself and any eligible dependents currently enrolled.**

**Member's Signature_____ Date_____**

**Sworn to before me this _____ day of_____, 20_____.**

**_____**
**Notary Public**