Iron Workers St. Louis District Council Trust Funds

P.O. Box 1096 • Maryland Heights, MO 63043 • Phone 314.656.1091 • Toll Free 877.597.8704 • Fax 314.739.1105

Retiree Dental Program - Election Form

Please complete, sign, and return this form

❑ **Yes -** Please enroll me and any covered dependents under the Plan in the Retiree Dental Program provided by Delta Dental of Missouri. I understand that I must pay the required monthly rate as indicated below to continue dental benefits under the Plan.

	Delta Dental Rate Effective 11/01/2019
Single	$33.50
Family	$62.00

❑ **No -** I do not wish to enroll in the Retiree Dental Program provided by Delta Dental of Missouri. I understand that by choosing this option at this time, dental benefits will not be available to me or my covered dependents at a later date.

If you do not return this Enrollment Form, you will not be enrolled in the Retiree Dental Program.

Member Name (please print): _____

Member Social Security Number or Alternate ID: _____

Member Phone Number: _____

Member's Signature: _____Date: _____