New York State Teamsters Council - UPS Retiree Health Fund
Enrollment Form

P.O. Box 4928 Syracuse, New York 13221-4928
Telephone 315.455.9790 · Facsimile 315.234.1047
email: benefits@nytfund.org

Retiree Information - Section #1

_____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ ☐ Male
Social Security Number Date of Birth ☐ Female

_____ _____
Telephone Number Date of Retirement

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Medicare Number (if applicable) _____

Part A Effective Date _____

Part B Effective Date _____

☐ I wish to defer participation in the New York State Teamsters Council – UPS Retiree Health Fund. Please complete Section 7 and return to this office. Please be advised, if you defer participation you will be eligible to enroll in these products at a future date as long as you can provide proof of continuous coverage (*see Section 3(E) of the Summary Plan Description*).

Spousal Information - Section #2

_____ _____ _____
Spouse Last Name Spouse First Name Middle Initial

_____ _____ ☐ Male
Social Security Number Date of Birth ☐ Female

Medicare Number (if applicable) _____
Part A Effective Date _____
Part B Effective Date _____

Is your spouse employed?
☐ Yes ☐ No

If yes, your spouse's employer is required to complete the Coordination of Spouse Benefits Form. Your spouse may not be eligible to participate in this Fund if certain conditions are present.

Coverage Selection - Section #3

(Select one): ☐ Individual ☐ Family

Other Coverage Information – Section #4

Will you, your spouse or any dependent be enrolled in any health, prescription or dental coverage after enrollment becomes effective in this Fund?

Health: ☐ Yes ☐ No

Who will the health plan cover? ☐ self ☐ spouse ☐ dependents

Other Insurance:

Carrier Name: _____

Name of Policyholder: _____

Policy ID Number: _____ Effective Date: _____

Prescription: ☐ Yes ☐ No

Who will the health plan cover? ☐ self ☐ spouse ☐ dependents

Other Insurance:

Carrier Name: _____

Name of Policyholder: _____

Policy ID Number: _____ Effective Date: _____

Dental: ☐ Yes ☐ No

Who will the dental plan cover? ☐ self ☐ spouse ☐ dependents

Other Insurance:

Carrier Name: _____

Name of Policyholder: _____

Policy ID Number: _____ Effective Date: _____

You **MUST** attach a copy of ALL insurance card(s) (FRONT and BACK); this would include identification cards for Medical, Prescription and Dental as appropriate.

Dependent Information – Section #5

_____	_____	_____
Dependent Last Name	Dependent First Name	Middle Initial

_____	_____	☐ Male
Social Security Number	Date of Birth	☐ Female

Is your Dependent handicapped or disabled? ☐ Yes ☐ No

Is Dependent Married? ☐ Yes ☐ No

If Dependent is between ages 19 - 25, are they a full time student*? ☐ Yes ☐ No

***If yes, please have the College/University complete the Request for Academic Certification form. Your Dependent will not be eligible until the certification has been received.**

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_____ _____ _____

Dependent Last Name Dependent First Name Middle Initial

_____ _____ ☐ Male

Social Security Number Date of Birth ☐ Female

Is your Dependent handicapped or disabled? ☐ Yes ☐ No

Is Dependent Married? ☐ Yes ☐ No

If Dependent is between ages 19 - 25, are they a full time student*? ☐ Yes ☐ No

***If yes, please have the College/University complete the Request for Academic Certification form. Your Dependent will not be eligible until the certification has been received.**

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_____ _____ _____

Dependent Last Name Dependent First Name Middle Initial

_____ _____ ☐ Male

Social Security Number Date of Birth ☐ Female

Is your Dependent handicapped or disabled? ☐ Yes ☐ No

Is Dependent Married? ☐ Yes ☐ No

If Dependent is between ages 19 - 25, are they a full time student*? ☐ Yes ☐ No

***If yes, please have the College/University complete the Request for Academic Certification form. Your Dependent will not be eligible until the certification has been received.**

Pension Deduction Authorization – Section #6

By signing this enrollment form below, I hereby authorize the New York State Teamsters Conference Pension and Retirement Fund to withhold my required monthly contribution from my pension check and immediately pay said sum to the New York State Teamsters Council – UPS Retiree Health Fund. This authorization shall continue in full force and effect from month to month until such time as written notice is given to revoke my authorization.

Acknowledgement & Signature – Section #7

If there are any changes in your address, marital status, other coverage information or dependents, you are required to notify the Fund Office immediately. Any person who knowingly makes a false statement with regard to a material fact shall not be entitled to receive the benefits claimed during this period.

_____ _____

Retiree Signature Date