New York State Teamsters Benefit Funds

PO Box 4928 • Syracuse, New York 13221-4928 • Telephone: 315-455-9790 • Facsimile 315-234-1046 • e-mail: benefits@nytfund.org

Municipal Enrollment Form

MEMBER INFORMATION SECTION

Last Name _____ First Name _____ Middle Initial _____

Email address _____

Mailing Address _____ City _____ State _____ Zip Code _____ Telephone Number _____

Social Security Number _____ Date of Birth _____ ❑ Male ❑ Female Employer _____ Date of Hire _____ Local Union _____

Marital Status ❑ Single ❑Married _____ Date ❑ Divorced _____ Date ❑Widowed

Coverage Selection: (Select One) **❑Single** **❑Two Person** **❑Family** **❑OPT-OUT - No Coverage (New Group only)** **❑OPT-OUT (Dependent Only)**

SPOUSE INFORMATION SECTION

Last Name _____ First Name _____ Middle Initial _____

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

Is Spouse employed? ❑ Yes ❑ No If Yes: Employer Name _____ Employer Address _____ Type: ❑ Single ❑ Family

Is spouse covered for benefits through their employer? ❑ Yes ❑ No If Yes: Type of Benefits Provided (i.e. medical, dental , vision) _____ Carrier Name _____

Is there a cost to your spouse's insurance? ❑ Yes ❑ No

CHILDREN INFORMATION SECTION

First Name	Last Name	Date of Birth	SS#	Relationship

BENEFICIARY DESIGNATION REQUIRED
(APPLICABLE IF LIFE INSURANCE BENEFIT INCLUDED)

FULL Name of Beneficiary _____ **COMPLETE** Address of Beneficiary _____ Relationship _____ Percentage _____

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If more than one beneficiary is named, the death benefits, unless a different percentage is indicated, will be paid equal shares to the designated beneficiaries who survive the employee. If no beneficiary survives, payment will be made in accordance with the rules adopted by the Trustees. I understand that by my participation in the program of the New York State Teamsters Council Health & Hospital Fund, any death benefits payable under such program shall be payable to the beneficiary above named by me. I further understand that the beneficiary designated may be changed by me at any time by written notification to the Fund.

If there are any changes in your employment or spouse's employment, address, beneficiary, or dependents, you are to notify this 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 nor any disability benefits during the period.

MEMBER'S SIGNATURE _____ **Date** _____

(SEE REVERSE FOR INSTRUCTIONS)

2021

ENROLLMENT INSTRUCTIONS

Complete <u>all</u> required fields on the reverse side
<u>In addition, you are required to provide the following documents:</u>

1. Copies of **birth certificates** or **drivers license** on yourself and spouse;
   Copies of **birth certificates** on dependent children showing names of natural parents.

2. If **married**, a copy of your marriage certificate.

3. For any children that may be **adopted**, a copy of adoption agreement.

4. For any **stepchildren** that are residing with you:
   - copy of your spouse's divorce decree.
   - separation agreement or family court order stating custody and insurance responsibility.
   - copy of last year's Federal Income Tax Return showing dependents reside with you.
   - written verification from school showing proof of residence on stepchild.

5. For any **grandchildren** that are residing with you:
   - copy of the court decree awarding custody.
   - the grandchild's birth certificate.
   - your last Federal Income Tax Return showing you claim the grandchild.

6. If **spouse is employed**:
   - The Fund needs to know if spouse's have insurance offered to have them at a cost **REGARDLESS** if they are enrolled

7. **SIGN and DATE** the BOTTOM of the ENROLLMENT FORM.

   - Return the completed enrollment form, along with the requested information.
   - If you have any questions concerning your enrollment responsibilities, please contact the Fund Office at (315) 455-9790.

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