

New York State Teamsters Council Health & Hospital Fund

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	
Street Address		City	State	Zip Code	Home Telephone Number	
Social Security Number		Date of Birth	Employer	Date of Hire	Local Union	
Job Title		<input type="checkbox"/> Bargaining <input type="checkbox"/> Non-Bargaining				
Marital Status		<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	
		Date	Date			

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	
<input type="checkbox"/> Male <input type="checkbox"/> Female						
Date of Birth		Social Security Number				
Is Spouse employed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			
Employer Name		Employer Address		Type:		
Is spouse covered for benefits through their employer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:		<input type="checkbox"/> Single <input type="checkbox"/> Family	
Type of Benefits Provided (i.e. medical, dental, vision)		Carrier Name				

CHILDREN INFORMATION SECTION

First Name	Last Name	Date of Birth	SS#	Relationship	(For children 19 & older only) School Attending & Graduation Date

BENEFICIARY DESIGNATION

Full Name of Beneficiary	Address of Beneficiary	Relationship	Percentage
Full Name of Beneficiary	Address of Beneficiary	Relationship	Percentage

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 wife'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)

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Enrollment Instructions For Municipal Employees

**Complete all the requested information on the reverse side
In addition, you are required to provide:**

1. Copies of birth certificates or drivers license on yourself and spouse and copies of birth certificates on dependent children showing names of natural parents ;
2. If you are 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, a copy of your spouse's divorce decree, separation agreement or family court order stating custody and insurance responsibility, and a copy of last year's Federal Income Tax Return showing dependents reside with you or written verification from school showing proof of residence on stepchild ;
5. For any grandchildren that are residing with you, a copy of the court decree awarding custody, as well as the grandchild's birth certificate and your last Federal Income Tax Return;
6. For any young adult dependent age 19 to age 26 that is either attending college or is employed and is NOT offered Health Insurance through their own employment or through a spouse's if married;
7. If spouse is employed, please have the enclosed form completed by their employer.

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

New York State Teamsters Benefit Funds

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