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 _____ Date of Birth _____

❑ Male ❑ Female Social Security Number _____

1.) Is your spouse employed?
❑ Yes ❑ No

Employer Name _____ Employer Phone _____

2.) Does your spouse's employer offer insurance?
❑ Yes ❑ No

3.) Is the insurance that is offered through their employer free (at no cost)?
❑ Yes (Spouse must enroll)
❑ No (Spouse does not need to enroll)

4.) Is your spouse enrolled in their benefits through their employer?
❑ Yes
❑ No

Carrier Name _____

Type of Benefits Enrolled in (i.e. medical, dental, vision) _____

Type:
❑ Single
❑ Family

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) 2026

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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Important Information About the New York State Teamsters Council Health and Hospital Fund
Initial Notification of Electronic Delivery and Your Right to Opt-out

This document includes important information about how we deliver certain documents to participants in the New York State Teamsters Council Health and Hospital Fund ("Health Fund"). This notice is to inform you that certain Health Fund Documents required to be furnished to you under ERISA will be furnished to you electronically by being posted online at https://nytfund.org/health-and-hospital-fund-plan-docs/. You will receive a notice to your email address when a document is posted on the website, along with a hyperlink to the website. Documents that will be posted online include, for example:

- Summary Plan Descriptions
- Summaries of Material Modifications
- Summary Annual Reports
- Summaries of Benefits and Coverage
- Women's Health and Cancer Rights Act Notice
- HIPAA Privacy Notice

How to Access Your Health Plan Documents Online

To access the documents posted on the website, you will need to type https://nytfund.org/health-and-hospital-fund-plan-docs/ into your internet browser, which will take you to the website where you can access the documents. Most modern internet browsers have built-in PDF readers. If your browser does not have a built-in PDF reader, your smartphone, tablet or computer must otherwise have PDF reader software to view the documents.

Documents at this website are not required to remain available for more than one year or, if later, after the document is superseded by a subsequent version of the document (such as a new Summary Plan Description).

Automatic Enrollment into Electronic Delivery

By providing your email address and signing the attached Enrollment Form you acknowledge and affirm that you have the ability to access the information in the form used in Electronic Delivery and will be automatically enrolled in Electronic Delivery. However, you have the right of Opting Out of Electronic Delivery and receiving paper versions of these documents at no charge by checking the box below and returning this document to the Fund Office:

Opting Out of Electronic Delivery

To elect Opting Out of Electronic Delivery, please complete the information below and mail to the New York State Teamsters Benefit Funds, PO Box 4928, Syracuse, NY 13221.

☐ ***I do not consent to receiving electronically the employee benefit plan-related disclosures described to me in an email from the Health Fund. I request paper versions be mailed to my home address on file. I understand I have the right to later enroll in Electronic Delivery by notifying the Fund Office.***

Name: _____
Fund ID#: _____

Signature: _____

You should keep this notice with your important papers relating to the Health Fund so that you know how to access your SPD, SMMs, and other important Health Fund documents that have previously been provided to you and include important information related to your Health Fund terms.

April, 2026