# 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 _____

**FULL** Name of Beneficiary _____ **COMPLETE** 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 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.

**New York State Teamsters Benefit Funds**
**PO Box 4928**
**Syracuse, New York 13221-4928**
**Telephone: (315) 455-9790 / Facsimile: (315) 234-1046**
**e-mail: <u>benefits@nytfund.org</u>**