

# 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](mailto:benefits@nytfund.org)

## Health and Pension Enrollment

### 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: YOU WILL BE ENROLLED IN YOUR MARITAL / FAMILY STATUS.**

### SPOUSE INFORMATION SECTION

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Initial

Male

Female

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

Is Spouse employed?  Yes  No

If Yes: \_\_\_\_\_

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Employer Address

Type:  Single  Family

Is your 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

\_\_\_\_\_  
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)

# ENROLLMENT INSTRUCTIONS

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

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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