New York State Teamsters Council - UPS Retiree Health Fund
Enrollment Form

P.O. Box 4928, Syracuse, New York 13221-4928
Telephone 315.455.9790 · Facsimile 315.234.1047
email: benefits@nytfund.org

Retiree Information - Section #1

_____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ ☐ Male _____
Social Security Number Date of Birth ☐ Female E-mail Address

_____ _____ _____
Telephone Number Date of Retirement Effective Date of Coverage

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Medicare Number* (if applicable) _____

Part A Effective Date* _____
Part B Effective Date* _____

**** Be advised the Plan provisions state that benefits are reduced by the amount Medicare would have paid for services (i.e. that you are enrolled in both Medicare Part's A & B). You are responsible for ensuring that you are properly enrolled in eligible Medicare programs.***

☐ I wish to defer participation in the New York State Teamsters Council – UPS Retiree Health Fund. Please complete Section 7 and return to this office. Please be advised, if you defer participation you will be eligible to enroll in these products at a future date as long as you can provide proof of continuous coverage (*see Section 3(E) of the Summary Plan Description*).

Spousal Information - Section #2

_____ _____ _____
Spouse Last Name Spouse First Name Middle Initial

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

Medicare Number* (if applicable) _____

Part A Effective Date* _____
Part B Effective Date* _____

**** Be advised the Plan provisions state that benefits are reduced by the amount Medicare would have paid for services (i.e. that you are enrolled in both Medicare Part's A & B). You are responsible for ensuring that you are properly enrolled in eligible Medicare programs.***

Is your spouse employed?

☐ Yes ☐ No

If yes, your spouse's employer is required to complete the Coordination of Spouse Benefits Form. Your spouse may not be eligible to participate in this Fund if certain conditions are present.

Coverage Selection - Section #3

(Select one): ☐ Individual ☐ Family

Other Coverage Information – Section #4

Will you, your spouse or any dependent be enrolled in any health, prescription or dental coverage after enrollment becomes effective in this Fund?

Health: ☐ Yes ☐ No

Who will the health plan cover? ☐ self ☐ spouse ☐ dependents

Other Insurance:

Carrier Name: _____

Name of Policyholder: _____

Policy ID Number: _____ Effective Date: _____

Prescription: ☐ Yes ☐ No

Who will the health plan cover? ☐ self ☐ spouse ☐ dependents

Other Insurance:

Carrier Name: _____

Name of Policyholder: _____

Policy ID Number: _____ Effective Date: _____

Dental: ☐ Yes ☐ No

Who will the dental plan cover? ☐ self ☐ spouse ☐ dependents

Other Insurance:

Carrier Name: _____

Name of Policyholder: _____

Policy ID Number: _____ Effective Date: _____

You **MUST** attach a copy of ALL insurance card(s) (FRONT and BACK); this would include identification cards for Medical, Prescription and Dental as appropriate.

Dependent Information – Section #5

_____ _____ _____

Dependent Last Name Dependent First Name Middle Initial

_____ _____ ☐ Male

Social Security Number Date of Birth ☐ Female

Is your Dependent handicapped or disabled? ☐ Yes ☐ No
Is Dependent Married? ☐ Yes ☐ No
If Dependent is between ages 19 - 25, are they a full time student*? ☐ Yes ☐ No

***If yes, please have the College/University complete the Request for Academic Certification form. Your Dependent will not be eligible until the certification has been received.**

****

_____ _____ _____
Dependent Last Name Dependent First Name Middle Initial

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

Is your Dependent handicapped or disabled? ☐ Yes ☐ No
Is Dependent Married? ☐ Yes ☐ No
If Dependent is between ages 19 - 25, are they a full time student*? ☐ Yes ☐ No

***If yes, please have the College/University complete the Request for Academic Certification form. Your Dependent will not be eligible until the certification has been received.**

****

_____ _____ _____
Dependent Last Name Dependent First Name Middle Initial

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

Is your Dependent handicapped or disabled? ☐ Yes ☐ No
Is Dependent Married? ☐ Yes ☐ No
If Dependent is between ages 19 - 25, are they a full time student*? ☐ Yes ☐ No

***If yes, please have the College/University complete the Request for Academic Certification form. Your Dependent will not be eligible until the certification has been received.**

Pension Deduction Authorization – Section #6

By signing this enrollment form below, I hereby authorize the New York State Teamsters Conference Pension and Retirement Fund to withhold my required monthly contribution from my pension check and immediately pay said sum to the New York State Teamsters Council – UPS Retiree Health Fund. This authorization shall continue in full force and effect from month to month until such time as written notice is given to revoke my authorization.

Acknowledgement & Signature – Section #7

If there are any changes in your address, marital status, other coverage information or dependents, you are required to notify the Fund 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 during this period.

_____ _____
Retiree Signature Date

Important Information About the
New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health 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 – United Parcel Service ("UPS") Retiree Health Fund. This notice is to inform you that certain UPS Retiree 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/ups-retiree-health-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
- Women's Health and Cancer Rights Act Notice
- HIPAA Privacy Notice

How to Access Your Retiree Health Plan Documents Online

To access the documents posted on the website, you will need to type https://nytfund.org/ups-retiree-health-fund-plan-docs/ into your internet browser, which will take you to the website where you can access the documents. Most modern internet browser 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 UPS Retiree 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 UPS Retiree Health Fund so that you know how to access your SPD, SMMs, and other important UPS Retiree Health Fund documents that have previously been provided to you and include important information related to your UPS Retiree Health Fund terms. April, 2026