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 315.234.1046 email: benefits@nytfund.org

Last Name	First Name	Middle Initial			_
Street Address		City		State	Zip Code
Social Security Number	Date of Birth	Date of Birth			
Telephone Number	Date of Retirement		Effective Date of Coverage		rage
Marital Status Single	Married Divorced	☐ Leg	gally Separated	☐ Wie	dowed
Medicare Number* (if applicable)					
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* Be advised the Plan provisions st services (i.e. that you are enrolled	tate that benefits are reduced in both Medicare Part's A chare programs. The New York State Teamstor this office. Please be advisured at each of the control of the contro	ed by the & B). Your ers Councilised, if you	cil – UPS Retire ou defer particip	ele for en e Health ation you	Fund. Please a will be eligible to
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		Cove	rage Selectio	n - Section #3	
(Select one):	☐ Individu	ıal	☐ Fa	amily	
	Oth	er Cov	erage Inforn	nation – Section #	4
Will you, your spot becomes effective i		lent be em	rolled in any hea	lth, prescription or denta	al coverage after enrollment
Health:	Yes No				
Who will the health	plan cover?	self	spouse	dependents	
Other Insurance: Carrier Nar Name of Po	olicyholder:			ve Date:	
Prescription:			Effecti		
Who will the health		self	spouse	dependents	
Other Insurance: Carrier Nar Name of Po Policy ID N	olicyholder:			ve Date:	
Dental:	Yes No				
Who will the dental	plan cover?	self	spouse	dependents	
Other Insurance: Carrier Name of Policy ID N	olicyholder:			ve Date:	
You MUST attach		isurance c	ard(s) (FRONT a		include identification cards

Male Sourity Number Date of Birth Female Sourity Number Date of Birth Gependent Will not be eligible until the certification has been received. Male		1	nation – Section	
ocial Security Number	Dependent Last Name	Dependent First Name	Mic	ddle Initial
ocial Security Number			□ Mala	
Spependent Married? Yes No F 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. Dependent will not be eligible until the certification has been received. Popendent Last Name	Social Security Number	Date of Birth	=	
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If yes, please have the College/University complete the Request for Academic Certification form. Dependent will not be eligible until the certification has been received. Dependent Last Name	•	25 are they a full time studer	= =	
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Male Ocial Security Number Date of Birth Female				
Male Ocial Security Number Date of Birth Female	Dependent Last Name	Dependent Firs	st Name	Middle Initial
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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 un	til such time as written notic	ce is given to revoke my
authorization.		
Acknowledgement & S	Signature – Section #7	
If there are any changes in your address, marital status, other notify the Fund Office immediately. Any person who knows shall not be entitled to receive the benefits claimed during the	ngly makes a false statement	
Retiree Signature	Date	