New York State Nurses Association
NYSNA Benefits Fund
PO Box 12430
Albany, NY 12212-2430
(877) RN BENEFITS
www.rnbenefits.org

Social Security Number _____ **Code** _____
(To be filled out by Fund office)

Benefits Fund Enrollment Form

Please print clearly

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ Apt. _____ Birth Date _____/_____/_____

City _____ State _____ ZIP code _____-_____

Home Phone (____) _____ Cell Phone (____) _____ E-mail _____ ☐ Male ☐ Female

Employer _____ Employment Date _____/_____/_____

Position Title _____ Work Status ☐ Full time ☐ Part time ☐ Per diem

Dependents (Spouse, children, stepchildren, ward) ***Marriage and birth certificates are required for coverage.***

Spouse Last Name _____ First Name _____ Birth Date ____/____/_____

Spouse's Health Insurance Company _____ Company's Phone Number (____) _____

Spouse's Insurance ID Number _____ Spouse's Social Security Number _____

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____

Life Insurance Beneficiary

If you would like to name more than two beneficiaries for your life insurance, please send the Fund office a notarized letter with all beneficiary names, addresses, Social Security numbers, and relationships listed. If more than one person is named beneficiary, the death benefit will be paid in equal shares to the designated beneficiaries who survive the participant, unless otherwise indicated. If no beneficiary survives, payment will be made in accordance with the terms of the policy.

First Beneficiary Full Name _____

Address _____ City _____ State _____ ZIP _____

Beneficiary Social Security Number _____ Relationship _____

Second Beneficiary Full Name _____

Address _____ City _____ State _____ ZIP _____

Beneficiary Social Security Number _____ Relationship _____

Important Notice

This form must be completed, signed, and received at the Fund office for your Benefits Fund coverage to start. Any person who knowingly and with intent to defraud any insurance company (or other person) files an application for insurance or statement of claim containing any materially false (or conceals for the purpose of misleading) information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and also is subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, pharmacy, or other organization or person having any records of information concerning the health and treatment of me and my dependents to furnish such records to the NYSNA Benefits Fund or its authorized representative, insurance company, or third party administrator.

Signature of Participant _____ Date _____