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 Open Enrollment Form - 2016

For effective date January 1, 2017 (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 _____

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 _____