



Benefits Fund Open Enrollment Form - 2017

For effective date **January 1, 2018** (Please print clearly)

The NYSNA Benefits Fund's 2017 open enrollment period runs from November 1, 2017 through December 31, 2017. In order for the changes below to be made and effective January 1, 2018, this form must be completed, signed, and received in the Fund office by December 31, 2017.

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 _____

Spouse's Birth Date ____/____/____ Male Female

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

I hereby state that the information provided above is true and correct, to the best of my knowledge. I understand and acknowledge that the NYSNA Benefits Fund will rely upon the information provided herein to determine eligibility for coverage under the Fund for me and my dependents. I further understand that if the NYSNA Benefits Fund incorrectly pays benefits on behalf of me or my dependents based upon inaccurate information provided by me herein, I may be required to reimburse the Fund for any benefits incorrectly paid and coverage may be rescinded.

Signature of Participant _____ Date _____