New York State Nurses Association

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 - Plan Year 2020

For effective date January 1, 2020 (Please print clearly)

The NYSNA Benefits Fund's 2019 open enrollment period runs from November 1, 2019 through December 31, 2019. In order for the changes below to be made and effective January 1, 2020, this form must be completed, signed, and received in the Fund office by December 31, 2019.

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 ____________