New York State Nurses Association
NYSNA Benefits Fund
PO Box 12430
Albany, NY, 12212-2430
PHONE (877) RN BENEFITS
FAX (518) 869-2317
www.rnbenefits.org

Young Adult Election Form

Participant Information

Last Name: _____ First Name: _____

Street: _____ City: _____

State: _____ ZIP Code: _____

Social Security Number: _____

Employer: _____

Young Adult Information (Applicant)

Last Name: _____ First Name: _____

Street: _____ City: _____

State: _____ ZIP Code: _____

Social Security Number: _____

My dependent young adult (check all that apply):

__ Is single __ Is under the age of 30 __ Lives, works, or resides in the State of New York

__ Does not live, work, or reside in the State of New York, but is a full-time student

__ Is employed by (name of employer) _____

(address of employer) _____

__ Is not insured by or eligible for health insurance coverage through his or her own employer or covered by Medicare (written verification by employer is required).

To qualify for coverage, the dependent must be less than 30 years of age; single; live, work, or reside in the State of New York (unless a full-time student); not insured by or eligible for health insurance coverage through his or her own employer; and not be covered under Medicare. I understand that it is my responsibility to notify the Benefits Fund within 31 days if my dependent becomes ineligible.

Signature of Participant or Applicant: _____

Date: _____

Mail this form, any required proof, and the first month's premium payment to:

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