1199SEIU Greater New York Benefit Fund

330 West 42nd Street, New York, NY 10036-6977 • www.1199SEIUBenefits.org
Tel (646) 473-9200 • Outside NYC Area Codes: (800) 575-7771

Enrollment Form for Young Adult Coverage

Instructions

1. Complete a separate application for Young Adult coverage for each dependent child from age 19 up to age 26 for whom you are requesting Benefit Fund coverage.
2. Send a copy of your child's Birth Certificate and Social Security Card along with this completed form, signed by the member and the dependent, to:

1199SEIU Benefit and Pension Funds · Member Eligibility Department
PO Box 1035 · New York, NY 10108-1035

Member's Information

Member's Full Name: _____

Member ID: _____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F
                                    Month   Day   Year

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____ Cell #: (_____) _____

Email Address: _____

Young Adult's Information

Dependent's Full Name: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F
                                                Month   Day   Year

Address (if different from member): _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____ Cell #: (_____) _____

Email Address: _____

Does Your Dependent's Other Parent Have Access to Other Health Insurance? ☐ Yes ☐ No

If Yes, Please Provide Other Parent's Full Name: _____

Other Parent's Date of Birth: _____/_____/_____
                              Month   Day   Year

If Yes to the above, please provide Other Parent's Employer Information:

• Employer's Full Name: _____

Employer's Address: _____ City: _____ State: _____ Zip Code: _____

Employer's Telephone: (_____) _____

Please Indicate the Type of Coverage (Check all that apply):

☐ Medical   ☐ Hospital   ☐ Prescription   ☐ Dental   ☐ Vision

• Effective Date of Coverage: _____/_____/_____
                              Month   Day   Year

• Name of Insurance Plan: _____

Policy/Group Number: _____ Insurance Plan Telephone: (_____) _____

This enrollment form is for Fund use only, and it will not be released to any third party except where necessary for the administration and operation of the Fund, or where otherwise required by law. The foregoing statements are to the best of my knowledge true and complete. I authorize any hospital, physician or other healthcare provider to release to the Fund and its agents any records of information, without restriction, concerning me or any member of my family receiving benefits from the Fund. Unless I revoke it in writing, this authorization will be effective as long as I am a participant in the Fund. A photocopy of this authorization shall be as valid as the original. I understand that under the terms of the plan (SPD), the Fund has a right to be reimbursed for any money it pays on my behalf for expenses caused by a third party. If the Fund pays any such claims, it will have a lien on payments I receive from, or on behalf of, the third party, and I agree to pay back the Fund for any payments it has made. This agreement will be effective for all benefits incurred while I am a participant in the Fund, even if I receive payments from, or on behalf of, a third party when I am no longer a participant.

I certify that the foregoing is true and correct.

Member's Signature **X** _____ Date: _____

Dependent's Signature **X** _____ Date: _____

You and your dependent must sign the form or it will be returned and your dependent will not be enrolled.