NY44 Health Benefits Plan Trust
www.ny44.e1b.org

Independent Health - ACTIVE EMPLOYEES

ALL SECTIONS MUST BE COMPLETED BEFORE PROCESSING.
RETURN COMPLETED APPLICATION TO YOUR EMPLOYER.

BENEFIT ADMINISTRATOR USE ONLY

Date Application Rec'd: _____

Dependent(s) photocopies received for:

☐ SS Card(s) ☐ Birth Certificate(s)

Entered into Bswift: _____

Effective Date: _____

OFFICE USE ONLY Name:

Must choose one: ☐ TRADITIONAL

1. Type: ☐ Single ☐ Employee & Spouse/Domestic Partner ☐ Employee & Child(ren) ☐ Family

2. Date of Hire: _____ Employer: _____ Bargaining Unit: _____

New Enrollment: (check one)
- ☐ New Hire
- ☐ Newly Eligible
- ☐ Open Enrollment

Must Choose One:
- ☐ Administrator
- ☐ Teacher
- ☐ SRP
- ☐ Non-Bargaining Unit

Applicant Changes: (check one)
- ☐ Name Change
- ☐ Address Change

Qualifying Life Events: (check one)*
- ☐ Add Dependent (e.g. birth, marriage, adoption, guardianship)
- ☐ Remove a Dependent (e.g. divorce, death)
- ☐ Loss of Other Coverage
- ☐ Termination of Employee Coverage
- ☐ Other _____ (Explain)

*Provide appropriate documents ***within 30 days of life event***. Refer to Section 3 "Eligibility, Enrollment and Conditions of Coverage" of the Summary Plan Description.

3. Applicant Information: PLEASE PRINT

_____ Gender: ☐ Male ☐ Female

Last Name First Name M.I Date of Birth (xx/xx/xxxx) Social Security Number (**Required**)

_____

Address: Permanent Residence (Street number, Street name, Apartment, Unit number; **P.O. Box is not allowed**)

_____

Address: Mailing Address (only if different from permanent address)

_____

City County State Zip + 4

(____)_____ (____)_____

Primary Telephone Cell Email Address (Required if available)

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Widowed

4. Family Information: (list all enrolling/changing/cancelling; attach additional sheet if necessary)

Spouse: _____ Gender: ☐ Male ☐ Female
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**)

Domestic Partner: _____ Gender: ☐ Male ☐ Female
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**)

Child:** _____ Gender: ☐ Male ☐ Female
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**)

Child: _____ Gender: ☐ Male ☐ Female
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**)

Child: _____ Gender: ☐ Male ☐ Female
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**)

****For Newborn children**, complete a new enrollment application within 30 days of birth. Provide newborn's social security number to Benefit Administrator when received.

5. Is your child(ren) named above between the ages of 19-26? ☐Yes ☐No

If yes, the NY44 Health Benefits Plan Trust in compliance with the Patient Protection and Affordable Care Act of 2010 for Children of Enrollees between the ages 19-26 requires proof of eligibility of dependent status. To confirm eligibility for coverage, photocopies of Social Security card and birth certificate must be provided to employer.

Dependent Out of Area ☐Yes ☐No
(If Yes, complete section on back of this application "For Dependents Out of Area"; dependent's permanent residence information is required.)

6. While enrolled in the Health Benefits Plan Trust, will you, your spouse or any of your dependents be covered by other medical insurance?
(for example Medicare, Other Employer Insurance, Medicaid) ☐Yes ☐No *If Yes, complete **Other Insurance** form (**Required**)

All information submitted on this first page is true, accurate and subject to applicant's Certification & Consent on Page 2 _____
(initials of applicant)

PLEASE COMPLETE THE REVERSE SIDE OF APPLICATION (Page 1 of 2)

7. Applicant Authorization:

CERTIFICATION & CONSENT

I certify that the information given on this application is current, true and correct to the best of my knowledge and I have read and agree to this statement. This application cannot be processed if Social Security Numbers are not provided (a birth date may be provided if a Social Security Number does not exist). I understand that any person who knowingly and with intent to defraud, files an enrollment application or claim for benefits containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and may also be subject to a civil monetary penalty.

I understand that this application and my, my spouse or eligible dependent's subsequent receipt of health care services are subject to the terms of the applicable coverage document and that it is my responsibility to verify the coverage available prior to obtaining any services under the Trust. I understand that 1.) if I enroll in the NY44 Health Benefits Plan Trust through my employer, the Trust in which my employer participates is responsible for remitting claim payments for the eligible individuals named on my application provided the claim is a covered service under the Trust; and 2.) there may be instances where treatment decisions made by my/our physicians or me/my covered dependents for medical expenses which are incurred may not be covered by the NY44 Health Benefits Plan Trust.

I understand that any person or institution who shall have rendered health services to me or to any member of my family under the applicable coverage document may make available to the Trust any documentation, records or information regarding such services. Any information received or generated by the Trust shall be kept confidential and secure as required by applicable law. I also understand that disclosure of my health information or the health information of any member of my family may occur as permitted by applicable law, to another provider, health plan, health care clearinghouse or other covered entity for purposes of treatment, payment or health care operations.

I attest that I have provided documentation of any and all other medical insurance coverage in which I, my spouse or my covered dependents are enrolled or through which we are receiving benefits. I acknowledge I cannot dis-enroll myself, my spouse or my dependents from coverage or enroll eligible family dependents for coverage unless I experience a qualifying life event as defined in the Summary Plan Description and when I have a qualifying life event I will notify my employer within 30 days of the event.

I have read and agree to the CERTIFICATION & CONSENT above. (**Required**)

Applicant's Signature: _____ Date: _____
Print Name:_____

The terms "You" and/or "Us" means the NY44 Health Benefits Plan Trust and/or a third-party administration company (TPA).

Please complete if applicable (see Item #5 of Page 1 of this application)

FOR DEPENDENTS OUT OF AREA

Name of Child: _____

Child's **PERMANENT RESIDENCE** Street Number, Street Name, City, State, and Zip Code:

_____

Child's **Contact Information** Primary telephone: _____

I understand that my child's coverage with the NY44 Health Benefits Plan Trust will end on the last day of the month in which he/she reaches his/her 26th birthday.

Applicant's Signature:_____ Date: _____
(**Required**)

Dependents Out of Area are dependents whose permanent residence is different than Applicant's residence listed on #3 on the front of application