New York State Nurses Association
NYSNA Benefits Fund
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 Enrollment Form

Please print clearly

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 __________________ Birth Date ____/____/_____

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 ___________________

Life Insurance Beneficiary

If you would like to name more than two beneficiaries for your life insurance, please send the Fund office a notarized letter with all beneficiary names, addresses, Social Security numbers, and relationships listed. If more than one person is named beneficiary, the death benefit will be paid in equal shares to the designated beneficiaries who survive the participant, unless otherwise indicated. If no beneficiary survives, payment will be made in accordance with the terms of the policy.

First Beneficiary Full Name ____

Address ____________________________________ City ______________ State ______ ZIP ________

Beneficiary Social Security Number ________________________________ Relationship _____________

Second Beneficiary Full Name ____

Address ____________________________________ City ______________ State ______ ZIP ________

Beneficiary Social Security Number ________________________________ Relationship _____________

Important Notice

This form must be completed, signed, and received at the Fund office for your Benefits Fund coverage to start. Any person who knowingly and with intent to defraud any insurance company (or other person) files an application for insurance or statement of claim containing any materially false (or conceals for the purpose of misleading) information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and also is subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, pharmacy, or other organization or person having any records of information concerning the health and treatment of me and my dependents to furnish such records to the NYSNA Benefits Fund or its authorized representative, insurance company, or third party administrator.

Signature of Participant ____________________________________ Date _______________