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 Open Enrollment Form - 2018

For effective date January 1, 2019 (Please print clearly)

The NYSNA Benefits Fund's 2018 open enrollment period runs from November 1, 2018 through December 31, 2018. In order for the changes below to be made and effective January 1, 2019, this form must be completed, signed, and received in the Fund office by December 31, 2018.

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provided by me herein, I may be required to reimburse the Fund for any benefits incorrectly paid and coverage may be rescinded.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 _____