New York State Nurses Association
NYSNA Benefits Fund
PO Box 12430
Albany, NY 12212-2430
(518)869-9501
www.rnbenefits.org

Social Security Number _____ **Code** _____
(To be filled out by Fund office)

Benefits Fund Open Enrollment Form - Plan Year 2026

For effective date January 1, 2026 (Please print clearly)

The NYSNA Benefits Fund's 2025 open enrollment period runs from November 1, 2025 through December 31, 2025. In order for the changes below to be made and effective January 1, 2026 this form must be completed, signed, and received in the Fund office by December 31, 2025.

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ Apt. _____ Birth Date _____/_____/_____

City _____ State _____ ZIP code _____-_____

Home Phone _____ Cell Phone _____

Personal email _____

By providing your email and cell phone number, you are agreeing to being contacted both via email and SMS (text messaging) from the Fund.

☐ Male ☐ Female ☐ Non-binary 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's Information: *Last Name* _____ *First Name* _____ *Birth Date* ___/____/____

☐ *Male* ☐ *Female* ☐ *Non-Binary* *Health Insurance Company* _____

Company's Phone Number (____) _____ *Effective date of insurance:* ___/___/___ *Social Security Number* _____/_____/_____

Insurance ID Number _____ *How is this insurance obtained? (employment/parent, etc.)* _____

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____ ☐ Male ☐ Female ☐ Non-Binary

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____ ☐ Male ☐ Female ☐ Non-Binary

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____ ☐ Male ☐ Female ☐ Non-Binary

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____ ☐ Male ☐ Female ☐ Non-Binary

Important Notice

This form must be completed, signed, and received at the Fund office for your Benefits Fund coverage to start.

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 _____