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 Enrollment Form

Please print clearly

Last Name _____ First Name _____ Middle Initial _____

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

City _____ State _____ ZIP code _____-_____

Home Phone _____ Cell Phone _____ Personal Email _____

☐Male ☐Female ☐Non-Binary

By providing your email address and cell phone number, you are giving us permission to contact you with important benefit updates and notices via SMS (text messaging) and email. You can choose to unsubscribe from either at any time.

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 ____/____/_____

☐Male ☐Female ☐Non-Binary

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 _____ ☐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

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.

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 _____

****This form must be printed and include a handwritten signature. Emailed photos of this form or electronic signatures will not be accepted.***