NEW YORK STATE TEAMSTERS BENEFIT FUNDS

YOUR ENROLLMENT RESPONSIBILITIES FOR THE HEALTH & HOSPITAL FUND

You are responsible for accurately completing and returning an enrollment card to the Fund Office. Your failure to do so could delay or preclude your eligibility or the payment of claims.

You are also responsible for providing:

1. *a certified copy of your birth certificate.*
2. *if you are married, a certified copy of your marriage certificate and a certified copy of your spouse's birth certificate.*
3. *a certified copy of the birth certificate or adoption agreement for each of your eligible dependent children.*
4. *a certified copy of your spouse's divorce decree from a prior marriage, if you wish to enroll a stepchild residing with you as an eligible dependent.*
5. *a certificate of attendance for each eligible dependent child age 19 to 23 attending college or other institution of higher education.*

Detach the enrollment card below. Complete both sides of the card and return it to the Fund Office.

Mail to:

New York State Teamsters Benefit Funds
Attn: Eligibility Department
PO Box 4928
Syracuse, NY 13221-4928

PLEASE PRINT ABOVE THE LINE

NEW YORK STATE TEAMSTERS BENEFIT FUNDS

Member's Last Name | Member's First Name | Middle Initial | Birth Date | S.S. Number | Male or Female

Home Telephone Number | Work Telephone Number

Address | No. | Street | City or Town | State | Zip Code | Local No.

☐ Single ☐ Married ___/___/___ (M D Y) ☐ Divorced ___/___/___ (M D Y) ☐ Widowed ___/___/___ (M D Y) ☐ Legally Separated ___/___/___ (M D Y)

MEMBER'S EMPLOYMENT INFORMATION

Employer | Insurance Co. | Provided by

Spouse | Employer | Insurance Co. | Provided by

Full Name of Beneficiary (Must be written) | Relationship to Member | Percentage

Full Name of Beneficiary (Must be written) | Relationship to Member | Percentage

If more than one beneficiary is named, the death benefits, unless a different percentage is indicated, will be paid in equal shares to the designated beneficiaries who survive the employee. If no such beneficiary survives, payment will be made in accordance with the rules adopted by the Trustees.

I understand that by my participation in the program of the New York State Teamsters Council Health & Hospital Fund, any death benefit payable under such program shall be payable to the beneficiary above named by me. I further understand that the beneficiary designated may be changed by me at any time by written notification to the Fund.

Member's Signature | Date

Be sure to fill in back of card listing names, Social Security numbers and dates of birth of Spouse and all Unmarried Children.

LIST NAME(S) AND SOCIAL SECURITY NUMBER OF SPOUSE AND UNMARRIED CHILDREN

Name(s) Oldest First		Check (x) Relationship					Date of Birth			School*	
First Name Last Name	Soc. Sec. No.	Spouse	Son	Dau	Stepson	Stepdau.	Mo.	Day	Year	H*	C*

*High School attendance for children over age 19 must be documented.

*College attendance must be documented each semester.

If there are any changes in your employment or your spouse's employment, address, beneficiary, or dependents, you are to notify this office immediately.

Any person who knowingly makes a false statement with regard to a material fact shall not be entitled to receive the benefits claimed nor any disability benefits during the period of 12 calendar months thereafter.

BE SURE YOU SIGN THE FRONT OF THE CARD