NY44 Health Benefits Plan Trust
www.ny44.org

DENTAL - COBRA

ALL SECTIONS MUST BE COMPLETED BEFORE PROCESSING.
RETURN COMPLETED APPLICATION TO YOUR EMPLOYER.

BENEFIT ADMINISTRATOR USE ONLY

Date Application Rec'd: _____

Dependent(s) photocopies received for:

☐ SS Card(s) ☐ Birth Certificate(s)

Entered into Bswift: _____

Effective Date: _____

OFFICE USE ONLY Name:

Must choose one:

1. Type: ☐ Single ☐ Family

2. Date of Hire: _____ Employer: _____ Bargaining Unit: _____

New Enrollment: (check one)

- ☐ New Hire
- ☐ Newly Eligible
- ☐ Open Enrollment

Must Choose One:

- ☐ Administrator
- ☐ Teacher
- ☐ SRP
- ☐ Non-Bargaining Unit

Applicant Changes: (check one)

- ☐ Name Change
- ☐ Address Change

Qualifying Life Events: (check one)*

- ☐ Add Dependent (e.g. birth, marriage, adoption, guardianship)
- ☐ Remove a Dependent (e.g. divorce, death)
- ☐ Loss of Other Coverage
- ☐ Termination of Employee Coverage
- ☐ Other _____(Explain)

*Provide appropriate documents *within 30 days of life event*. Refer to Section 3 Eligibility, Enrollment and Conditions of Coverage" of the Summary Plan Description.

3. Applicant Information: PLEASE PRINT

Last Name First Name M.I Date of Birth (xx/xx/xxxx) Social Security Number (**Required**) Gender: ☐ Male ☐ Female

Address: Permanent Residence (Street number, Street name, Apartment, Unit number; **P.O. Box is not allowed**)

Address: Mailing Address (only if different from permanent address)

City County State Zip + 4

( ) ( )
Primary Telephone Cell Email Address (Required if available)

MARITAL STATUS

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Widowed

4. Family Information: (list all enrolling/changing/cancelling; attach additional sheet if necessary)

Spouse: _____
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**) Gender: ☐ Male ☐ Female

Domestic Partner: _____
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**) Gender: ☐ Male ☐ Female

Child:** _____
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**) Gender: ☐ Male ☐ Female

Child: _____
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**) Gender: ☐ Male ☐ Female

Child: _____
Last Name First Name M.I. Date of Birth (MM/DD/YYYY) Social Security Number (**Required**) Gender: ☐ Male ☐ Female

** For Newborn children, complete a new enrollment application within 30 days of birth. Provide newborn's social security number to Benefit Administrator when received.

All information submitted on this first page is true, accurate and subject to applicant's Certification & Consent on Page 2 _____
(initials of applicant)

PLEASE COMPLETE THE REVERSE SIDE OF APPLICATION (Page 1 of 2)

5. Your child Dependents are covered under the NY44 Health Benefits Plan Trust until the end of the month in which they reach 24 years of age.

FOR DEPENDENTS OUT OF AREA

Name of Child: _____

Child's **PERMANENT RESIDENCE** Street Number, Street Name, City, State, and Zip Code:

_____

Child's **Contact Information** Primary telephone: _____

I understand that my child's coverage with the NY44 Health Benefits Plan Trust will end on the last day of the month in which he/she reaches his/her 24th birthday.

Applicant's Signature: _____ Date: _____

(**Required**)

Dependents Out of Area are dependents whose permanent residence is different than Applicant's residence listed on #3 on the front of application

6. While enrolled in the Health Benefits Plan Trust, will you, your spouse or any of your dependents be covered by any other dental insurance?

If so, please List additional dental insurance coverage here: _____

_____

_____

7. Applicant Authorization:

CERTIFICATION & CONSENT

I certify that the information given on this application is current, true and correct to the best of my knowledge and I have read and agree to this statement. This application cannot be processed if Social Security Numbers are not provided (a birth date may be provided if a Social Security Number does not exist). I understand that any person who knowingly and with intent to defraud, files an enrollment application or claim for benefits containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and may also be subject to a civil monetary penalty.

I understand that this application and my spouse or eligible dependent's subsequent receipt of dental services are subject to the terms of the applicable coverage document and that it is my responsibility to verify the coverage available prior to obtaining any services under the Trust. I understand that 1.) if I enroll in the NY44 Health Benefits Plan Trust through my employer, the Trust in which my employer participates is responsible for remitting claim payments for the eligible individuals named on my application provided the claim is a covered service under the Trust; and 2.) there may be instances where treatment decisions made by my/our dental professionals or me/my covered dependents for dental expenses which are incurred may not be covered by the NY44 Health Benefits Plan Trust.

I understand that any person or institution who shall have rendered dental services to me or to any member of my family under the applicable coverage document may make available to the Trust any documentation, records or information regarding such services. Any information received or generated by the Trust shall be kept confidential and secure as required by applicable law. I also understand that disclosure of my health/dental information or the health/dental information of any member of my family may occur as permitted by applicable law, to another provider, health/dental plan, health/dental care clearinghouse or other covered entity for purposes of treatment, payment or health/dental care operations.

I attest that I have provided documentation of any and all other dental insurance coverage in which I, my spouse or my covered dependents are enrolled or through which we are receiving benefits. I acknowledge I cannot dis-enroll myself, my spouse or my dependents from coverage or enroll eligible family dependents for coverage unless I experience a qualifying life event as defined in the Summary Plan Description and when I have a qualifying life event, I will notify my employer within 30 days of the event.

I have read and agree to the CERTIFICATION & CONSENT above. (**Required**)

Applicant's Signature: _____ Date: _____

Print Name: _____

The terms "You" and/or "Us" means the NY44 Health Benefits Plan Trust and/or a third-party administration company (TPA).