NORTH SHORE SCHOOLS FEDERATED EMPLOYEES BENEFIT TRUST FUND

COVERAGE ELECTION/REJECTION FORM FOR ACTIVE MEMBERS

PLEASE COMPLETE AND RETURN TO:

NORTH SHORE SCHOOLS FEDERATED EMPLOYEES
BENEFIT TRUST FUND
40 RAILROAD AVENUE
GLEN HEAD, NY 11545
516-759-9337

SECTION I **COVERAGE ELECTION/REJECTION OPTIONS:**

☐ **YES, I WOULD LIKE TO ELECT COVERAGE**

The bi-weekly payroll deduction (22 pay periods per year) Rates Effective January 1, 2018:

☐ **Individual $5.20** ☐ **Emp/Spouse $10.00** ☐ **Emp/Child $10.00** ☐ **Family $16.40**

☐ **NO, I DO NOT WISH TO ELECT COVERAGE AT THIS TIME**.

(EVEN IF YOU DO NOT WISH TO ENROLL IN THE PLAN, PLEASE COMPLETE, SIGN AND RETURN THIS FORM.) I understand that by declining coverage I will not be eligible for benefits during the coverage period, and that I will be subject to a twelve month waiting period before I can become eligible for benefits, except as prescribed in the Notice of HIPAA Special Enrollment Rights on the reverse side of the form.

SECTION I **MEMBER INFORMATION**

SOCIAL SECURITY NUMBER			DATE OF BIRTH
☐☐☐-☐☐-☐☐☐☐			☐☐/☐☐/☐☐☐☐
LAST NAME	**FIRST NAME**	**MI**	
ADDRESS	**APT NO.**	**CITY**	**STATE** **ZIP**

GENDER: ☐ **MALE** ☐ **FEMALE** **MARITAL STATUS:** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED**

HOME PHONE: **CELL:** **EMAIL ADDRESS**

ARE YOU, YOUR SPOUSE OR DEPENDENT CHILDREN COVERED BY ANOTHER DENTAL BENEFIT PROGRAM? ☐ **YES** ☐ **NO**

SECTION II **MEMBER SIGNATURE**

I HEREBY CERTIFY THAT ALL THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A DENIAL OR SUSPENSION OF BENEFITS. IN ADDITION, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR THE FUND OR FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

MEMBER'S SIGNATURE:_____ **DATE:**_____/_____/_____

PLEASE COMPLETE REVERSE SIDE OF FORM

IF ELECTING OTHER THAN INDIVIDUAL COVERAGE,

SECTION III SPOUSE/DOMESTIC PARTNER INFORMATION

☐ **SPOUSE** – (FUND RESERVES RIGHT TO REQUEST COPY OF MARRIAGE CERTIFICATE)

☐ **DOMESTIC PARTNER** – FUND RESERVES RIGHT TO REQUEST EMPIRE PLAN OR OTHER VALID CERTIFICATION OF ELIGIBILITY OF DOMESTIC PARTNER

SOCIAL SECURITY NUMBER	DATE OF BIRTH
☐☐☐-☐☐-☐☐☐☐	☐☐/☐☐/☐☐☐☐

FIRST NAME	LAST NAME	MI

GENDER: ☐ MALE ☐ FEMALE

IS SPOUSE/DOMESTIC PARTNER EMPLOYED? ☐ YES ☐ NO IF YES, EMPLOYER NAME:_____

DOES THIS EMPLOYER PROVIDE COVERAGE FOR	IF YES, PLEASE PROVIDE NAME, ADDRESS AND TELEPHONE NUMBER OF DENTAL PLAN AND ID NUMBER, IF APPLICABLE
DENTAL? ☐ YES ☐ NO	

SECTION IV DEPENDENT CHILD INFORMATION

- IF CHILD IS BETWEEN 19-24 YEARS OF AGE AND IS A FULL-TIME STUDENT, A STUDENT VERIFICATION FORM MUST BE FILED EACH SEMESTER. COVERAGE FOR FULL-TIME STUDENTS WILL TERMINATE WHEN THE FULL-TIME STUDENT REACHS HIS/HER 24TH BIRTHDAY. FUND RESERVES RIGHT TO REQUEST COPIES OF DEPENDENT CHILD(REN)'S BIRTH CERTIFICATE.

NAME	DATE OF BIRTH	SOCIAL SECURITY NO.
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐

Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at 516-759-9337