NORTH SHORE SCHOOLS FEDERATED EMPLOYEES BENEFIT TRUST FUND

40 RAILROAD AVENUE
GLEN HEAD, NY 11545
516-759-9337

RETIREE DENTAL COVERAGE ELECTION/REJECTION FORM

Dear Retiree:

This is your group dental plan coverage Election/Rejection form for period commencing January 1, 2017.
You have the option of electing paying for the six month period 1/1/2017 to 06/30/2017 or for a 12 month period 01/01/2017 to 12/31/2017.

SECTION I COVERAGE ELECTION/REJECTION OPTIONS:

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

BILLING OPTION	Individual	Retiree/Spouse	Retiree/Child	Family
6 MONTHS	☐ $264.89	☐ $540.53	☐ $617.21	☐ $ 873.47
12 MONTHS	☐ $529.78	☐ $1,081.06	☐ $1,234.42	☐ $1,746.94

Please Make Check Payable to: North Shore Schools Federated Employees Benefit Trust Fund and return it with this form in the enclosed envelope.

☐ **NO, I DO NOT WISH TO ELECT COVERAGE**. By not electing coverage now, I understand that if I wish to elect coverage at a later date, my coverage and benefits will be subject to the open enrollment periods and waiting periods as described in the NSSFE Benefit Trust Fund Member Benefits Booklet.

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**

PHONE DAY: **EVENING:** **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:**_____/_____/_____

IF ELECTING OTHER THAN INDIVIDUAL COVERAGE, PLEASE COMPLETE THIS SIDE OF FORM

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

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.
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐
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	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐