New York State Teamsters Benefit Funds

PO Box 4928 • Syracuse, New York 13221-4928 • Telephone: 315-455-9790 • Facsimile: 315-234-1046 • e-mail: nyst@aiusa.com

Health and Pension Enrollment

MEMBER INFORMATION SECTION

Member's Last Name | Member's First Name | Middle Initial

Street Address | City | State | Zip Code | Home Telephone Number ( )

Social Security Number - - | Date of Birth | ☐ Male ☐ Female | Employer | Date of Hire | Local Union

Marital Status (select one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

SPOUSE'S INFORMATION SECTION

Spouse's Last Name | Spouse's First Name | Middle Initial

Date of Birth | Male or Female | Social Security Number - -

Is spouse employed? ☐ Yes ☐ No — If yes: Employer Name | Employer Address

Is spouse covered for benefits? ☐ Yes ☐ No — If yes: Type of Benefits Provided (ie- medical, dental, vision) | Carrier Name | Type: ☐ Single ☐ Family

CHILDREN'S INFORMATION SECTION

First Name	Last Name	Date of Birth	SS#	Relationship	(For children 19 & older only) School Attending & Graduation Date

HEALTH FUND PARTICIPANTS -- PLEASE COMPLETE-- LIFE INSURANCE BENEFICIARY DESIGNATION

Full Name of Beneficiary must be written | Address of Beneficiary | Relationship | Percentage

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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.

PENSION FUND PARTICIPANTS -- PLEASE COMPLETE

1) Complete only the requested information concerning yourself and your spouse;
2) Sign and date the enrollment form;
3) Complete the Past Employment information below:

Company Name	Date Began	Date Terminated	Local No.

Member's Signature ______________________ Date ______________________

New York State Teamsters Benefit Funds

Your Funds Working for You

If you are enrolling yourself and any eligible dependents for Health Fund Benefits:

Complete all the requested information on the reverse side.
In addition, you are required to provide:

1) Copies of birth certificates for yourself, your spouse, and any eligible dependent children you are enrolling;
2) If you are married, a copy of your marriage certificate;
3) For any children that may be adopted, a copy of the adoption agreement;
4) For any stepchildren that are residing with you, a copy of your spouse's divorce decree, as well as the stepchild's birth certificate and your last Federal Income Tax return;
5) For any grandchildren that are residing with you, a copy of the court decree awarding custody, as well as the grandchild's birth certificate and your last Federal Income Tax return;
6) For any dependent child aged 19 to 23 that is attending an institution of higher learning, a certificate of attendance from that institution showing full time attendance.

BE SURE TO COMPLETE THE LIFE INSURANCE BENEFICIARY DESIGNATION AND SIGN THE BOTTOM OF THE ENROLLMENT CARD.

Return the completed enrollment form, along with the requested information to:
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If you have any questions concerning your enrollment responsibilities contact the Fund Office at (315) 455-9790.