Retiree Health and Welfare Fund

Police Benevolent Association of the City of New York

125 Broad Street – 11th Floor
New York, NY 10004
212-349-7560
www.nycpba.org

Dependent Enrollment Form – Retired Members

SECTION I – MEMBER'S INFORMATION						
Social Security Number	**Last Name**		**First Name**			**Middle Initial**
Date of Birth (MM/DD/YYYY) / /	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner				**Gender** ☐ Male ☐ Female	
Home Address Line 1	**Home Address Line 2**	**City**		**State**	**Zip Code**	
E-mail Address	**Home Telephone Number**		**Mobile Telephone Number**			

SECTION II – ADD NEW DEPENDENTS							
Relationship	**Last Name**	**First Name**	**SSN**	**Date of Birth**	**Gender**	**Disabled?***	**Medicare Eligible?**
☐ Spouse ☐ Domestic Partner ☐ Dependent Child					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Spouse ☐ Domestic Partner ☐ Dependent Child					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Spouse ☐ Domestic Partner ☐ Dependent Child					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Spouse ☐ Domestic Partner ☐ Dependent Child					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Spouse ☐ Domestic Partner ☐ Dependent Child					☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

Important Note: When adding or removing a dependent you must provide the applicable documentation (e.g., birth certificate, marriage certificate or copy of divorce decree).

For benefits related questions, please contact benefits@nycpba.org.

SECTION III – REMOVE EXISTING DEPENDENTS

Reason	Last Name	First Name	SSN	Date of Birth
☐ Divorce ☐ Death ☐ Loss of Dependent Child Status ☐ I wish to voluntarily remove eligible dependent ☐ Other				
☐ Divorce ☐ Death ☐ Loss of Dependent Child Status ☐ I wish to voluntarily remove eligible dependent ☐ Other				
☐ Divorce ☐ Death ☐ Loss of Dependent Child Status ☐ I wish to voluntarily remove eligible dependent ☐ Other				

***Dependent children may be covered beyond the age of 26 if they are: (1) unmarried; and (2) unable to support themselves due to a physical or intellectual disability or mental illness that occurred prior to age twenty-six (26); and (3) enrolled as a disabled child in the City of New York Health Benefits Program.**

SECTION IV – INFORMATION ABOUT OTHER HEALTH PLAN/INSURANCE COVERAGE

(A) – Plans other than the City of New York Health Benefits Program

Do any of your dependents have coverage through another employer or union (This includes other NYC Union Health and Welfare Funds, but not the City of New York Health Benefits Program)?

☐ **Yes** ☐ **No**

If you answered "Yes", please provide the following information:

Employer/Union Plan Name	
Policyholder/Subscriber Name	
Coverage Effective Date	
Coverage Termination Date (If applicable)	
Policy/Coverage Type	☐ Single ☐ Employee + Spouse ☐ Family
Benefits Provided (Check all that apply)	☐ Medical/Hospital ☐ Prescription Drugs ☐ Dental ☐ Vision

(B) – List of Covered Individuals (List all individuals, including yourself, with other coverage.)

Last Name	First Name	SSN	Date of Birth	Covered by Another Health Plan?	Enrolled in NYC Health Plan Prescription Drug Rider?
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

SECTION V - MEMBER'S SIGNATURE

I certify that the information in sections I, II, III, and IV above is correct. I understand that if I provide incorrect information and that information results in the Retiree Health and Welfare Fund making payments that it should not have made, I will be responsible for those payments.

Member's Signature: ______________________________ **Date:** ____________________

For Office Use Only: (Please do not write in this section)			
Received	Entered by:	Verified by:	Information requested: