PORT CHESTER TEACHERS ASSOCIATION WELFARE TRUST FUND

RE-ENROLLMENT FORM

(THIS FORM MUST BE FILLED OUT AND MAILED TO ADMINISTRATIVE SERVICES ONLY, INC.)

PLEASE SUBMIT FORM TO:
ADMINISTRATIVE SERVICES ONLY, INC.
PO BOX 9010
LYNBROOK, NY 11563
516-396-5500

ALL MEMBERS MUST COMPLETE, SIGN AND RETURN THIS FORM ALONG WITH COPIES OF REQUIRED DOCUMENTATION: MARRIAGE CERTIFICATE AND A DEPENDENT BIRTH CERTIFICATE FOR EACH DEPENDENT.

Members may decline coverage of the Fund benefits (Dental and Vision) for themselves and/or any enrolled dependents at any time by completing the Declination of Coverage form which is available at www.asonet.com.

SECTION I MEMBER INFORMATION

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ DATE OF BIRTH: MM-DD-YYYY ☐☐/☐☐/☐☐☐☐

MEMBER'S LAST NAME | FIRST NAME | MI

ADDRESS | APT NO. | CITY | STATE | ZIP

GENDER: ☐ MALE ☐ FEMALE

PERSONAL EMAIL ADDRESS:

PHONE HOME: | WORK: | CELL

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).

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 your new dependents. To request special enrollment or obtain more information, contact Administrative Services Only Inc. at 1-516-396-5500.

SECTION II ☐SPOUSE - PLEASE ATTACH COPY OF MARRIAGE CERTIFICATE OR

☐ **DOMESTIC PARTNER – PLEASE CONTACT ADMINISTRATIVE SERVICES ONLY, INC OR GO TO ASONET.COM FOR A DOMESTIC PARTNER ENROLLMENT FORM**

SPOUSE SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ **DATE OF BIRTH MM-DD-YYYY** ☐☐/☐☐/☐☐☐☐

SPOUSE'S LAST NAME | FIRST NAME | MI | EMAIL ADDRESS

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

DOES EMPLOYER PROVIDE: DENTAL PLAN? ☐ YES ☐ NO OPTICAL PLAN? ☐ YES ☐ NO

SECTION III DEPENDENT CHILD INFORMATION - A COPY OF EACH DEPENDENT'S BIRTH CERTIFICATE, ADOPTION CERTIFICATE OR PROOF OF LEGAL GUARDIANSHIP. •See "Affidavit of Dependency" form and fill out if applicable.

This coverage is available even if the child is eligible to enroll in another employer sponsored plan. This means even if a child was offered and/or is covered by his or her own employer, or his or her spouse's employer, then the parent's plan is still required to continue dependent coverage. **IF CHILD IS BETWEEN 19 AND 23 YEARS OF AGE AND IS A FULL-TIME STUDENT, STUDENT VERIFICATION FORM MUST BE FILED EACH SEMESTER THAT SERVICES ARE RENDERED**.

FIRST NAME LAST NAME	DATE OF BIRTH	GENDER	SOCIAL SECURITY NO.
		☐M ☐F	
RELATIONSHIP ☐My Child ☐Stepchild ☐ Adopted Child ☐ Other	There is a court order or agreement specifying that primary support or medical coverage for the dependent listed above is the obligation of an individual other than myself or my spouse ☐YES ☐ NO		
FIRST NAME LAST NAME	**DATE OF BIRTH**	**GENDER**	**SOCIAL SECURITY NO.**
		☐M ☐F	
RELATIONSHIP ☐My Child ☐Stepchild ☐ Adopted Child ☐ Other	There is a court order or agreement specifying that primary support or medical coverage for the dependent listed above is the obligation of an individual other than myself or my spouse ☐YES ☐ NO		
FIRST NAME LAST NAME	**DATE OF BIRTH**	**GENDER**	**SOCIAL SECURITY NO.**
		☐M ☐F	
RELATIONSHIP ☐My Child ☐Stepchild ☐ Adopted Child ☐ Other	There is a court order or agreement specifying that primary support or medical coverage for the dependent listed above is the obligation of an individual other than myself or my spouse ☐YES ☐ NO		
FIRST NAME LAST NAME	**DATE OF BIRTH**	**GENDER**	**SOCIAL SECURITY NO.**
		☐M ☐F	
RELATIONSHIP ☐My Child ☐Stepchild ☐ Adopted Child ☐ Other	There is a court order or agreement specifying that primary support or medical coverage for the dependent listed above is the obligation of an individual other than myself or my spouse ☐YES ☐ NO		
FIRST NAME LAST NAME	**DATE OF BIRTH**	**GENDER**	**SOCIAL SECURITY NO.**
		☐M ☐F	
RELATIONSHIP ☐My Child ☐Stepchild ☐ Adopted Child ☐ Other	There is a court order or agreement specifying that primary support or medical coverage for the dependent listed above is the obligation of an individual other than myself or my spouse ☐YES ☐ NO		

SECTION IV OTHER COVERAGE INFORMATION-

DO YOU OR ANY ONE OF YOUR DEPENDENTS HAVE OTHER COVERAGE FOR:	IF YES, PLEASE PROVIDE POLICY HOLDER NAME	IF YES, PLEASE PROVIDE NAME OF INSURANCE COMPANY/CARRIER AND POLICY NUMBER
DENTAL PLAN? ☐ YES ☐ NO		
OPTICAL PLAN? ☐ YES ☐ NO		

SECTION V MEMBER SIGNATURE

I HEREBY CERTIFY THAT ALL THE INFORMATION PROVIDED 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 PROVIDING MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

MEMBER'S SIGNATURE:____ **DATE:**_____/________/_______