BAC Local 8 NY Health Plan Enrollment Form 2023

Employee Name: _____ Date of Birth: _____

Address: _____

SS#:_____ Phone#:_____ Email: _____

☐ I elect to enroll myself, and the following eligible dependents in the BAC Local 8 NY Group Health Plan. I understand that I must return this form to be/remain enrolled in the Plan and will notify the Fund Office of any changes as they occur.

Dependent Name	DOB	Dependent SS#	Relationship to Employee
First Last	mm/dd/yyyy	123-45-6789	Spouse, Domestic Partner, (Step)Son, (Step)Daughter

Are you or any dependents enrolled in a health or dental insurance Plan other than the BAC (including Medicare or Medicaid)? ☐ No ☐ Yes

If yes: are you keeping the additional coverage? Health ☐No ☐ Yes/ Dental ☐ No ☐ Yes / Vision? ☐No ☐Yes

Who did/does the other plan cover? ☐Self ☐Spouse ☐Children

Other Insurance Carrier(s) Name: _____ Policyholder name: _____

Policy ID#_____ Effective Date: _____ Term Date:_____

☐ I do not wish to be enrolled in the BAC Local 8 NY Group Health Plan and understand that to re-qualify I will need to work at least 1200 hours during the eligibility year to earn coverage for the following coverage year. I also understand that to be eligible for Retiree Coverage I must have been covered by the Ithaca Health Plan for 10 consecutive years.

_____ _____

Member Signature Date: