**BAC Local 8 NY Health Plan Enrollment Form 2024**

Employee Name: ______________________________ Date of Birth: ________________________________________

Address: ____________________________________________________________________________________________
Address City State Zip

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, (Step)Son, (Step)Daughter, Domestic Partner (proof required) |
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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: ____________________

ID#:_________________________ Start Date: _______________ End Date:________________

*Please send copies of ID cards for other insurances including terminated plans.

☐ 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: