BAC Local 8 NY Health Plan Dependent Change Form

Employee Name: _____ Date of Birth: _____

Address: _____
Address City State Zip

SS#:_____ Phone#:_____ Email: _____

☐ I elect to add or remove the following dependents, as noted below, in the BAC Local 8 NY Group Health Plan. If adding, they will receive Medical and Rx coverage through Excellus BCBS and an $800 Dental/Optical benefit administered through LBS, effective the first day of the month following the receipt of this form by the Fund Office. I understand that I must return this form to complete enrollment and will notify the Fund Office of any changes as they occur. **If I am removing a dependent, I will submit proof of other insurance and the effective date with this form.**

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

Please complete the section below if you are *adding* a dependent:

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:_____

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

X _____
Member Signature Date