Health and Welfare Fund

Police Benevolent Association of the City of New York
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Dependent Enrollment Form – Active Members

SECTION I - MEMBER INFORMATION			
Social Security Number	Last Name	First Name	Middle Initial

Gender	Marital Status	Date of Birth (MM/DD/YYYY)	Tax Registry No.
☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Domestic Partner	/ /	

Home Address Line 1	Home Address Line 2	City	State	Zip Code

E-mail Address	Home Telephone Number	Mobile Telephone Number	Command

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

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

SECTION III – DROP EXISTING DEPENDENTS

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

***Dependent children may be covered beyond the age of 26 if they are: (1) unmarried; and (2) unable to support themself 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.**

PBA6

SECTION IV – Information About Other Health Plans/Insurance Coverage (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

SECTION V – Dependent Life Insurance (For PBA Members Only)

Dependent Life Insurance (DLI) pays a benefit to Active PBA Members in the event of the death of a dependent. DLI must be elected within 31 days of the later of (1) your appointment date, or (2) when your dependent is acquired (marriage, birth, etc.). If this deadline passes, you must provide evidence of good health (as required by the insurance carrier) for any dependents acquired more than 31 days prior to electing DLI. Dependent children can be covered under DLI until age 19 (25 if enrolled as a full-time student). Please note that DLI eligibility rules for dependent children are different from those for the Health and Welfare and Retiree Health and Welfare Funds.

If you have already elected DLI for existing dependents, new dependents are automatically covered. If you are unsure whether you have already elected DLI, please contact the PBA Funds Office.

If you elect DLI, the current premium of 47 cents ($0.47) will be deducted from your bi-weekly paycheck regardless of the number of dependents covered. Premium is subject to change.

Benefit Amounts:

- **$12,000 of coverage for a spouse or domestic partner.**
- **$3,000 of coverage for a dependent child.**

Please select one option below:

☐ **I wish to elect Dependent Life Insurance.**

☐ **I do not wish to elect Dependent Life Insurance.**

VI - Signature

Note: Please review the information you provided on this form. Be sure that you completed all of the required sections of your Dependent Enrollment Form (PBA-6), and that you included the required documentation (marriage certificate, birth certificate, certificate of domestic partnership, etc.)

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

Member's Signature: _____ **Date:** _____

For Office Use Only			
Received	Entered By	Verified By	Information Requested