PLEASE RETAIN TOP PORTION FOR YOUR RECORDS

- This enrollment form is for the UUP Benefit Trust Fund (BTF). The Fund provides dental and vision coverage for members of the Professional Services Negotiating Unit (PSNU) who are eligible for the New York State Health Insurance Program (NYSHIP) under the UUP/State collective bargaining agreement.
- This form must be completed and received in the Fund Office before benefits can be accessed. Completion of this form does not imply eligibility. You may verify eligibility for the UUP Benefit Trust Fund by calling the Fund Office at (800) 887-3863 or checking with your Campus Benefits Office.
- **Delta Dental Options:** If you are a new employee, or have never enrolled in the BTF, you can select DeltaCare USA as your dental plan and fill out a DHMO enrollment form. If you do not select DeltaCare USA you will automatically be enrolled in the Delta Dental PPO plan.

Date Signed and Mailed: _____

✂

Print Form, Complete, Sign and Mail or Fax to:

UUP Benefit Trust Fund, P.O. Box 15143, Albany, N.Y. 12212-5143

Fax (866) 559-0516

Please select one:

Delta PPO _____
Delta DHMO _____

Enrollment Card

UUP Benefit Trust Fund
P.O. Box 15143, Albany, NY 12212-5143
800-887-3863 or 800-UUP-FUND

Name (Last, First, Middle Initial) NY State Employee ID

Home Address – Number & Street City, State, Zip Code

Work Location (Name of Campus or Institution)

Date of Birth - ____/____/____ Home Phone - _____ Work Phone - _____

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Legally Separated** | ☐ **Male** ☐ **Female**

List below the name of spouse or domestic partner. Domestic partner information must be provided to your **campus benefits office**. Please also list children/dependents.

SPOUSE (*Check One*)			**(Please list Children/Dependents below)**		
Husb	**Wife**	**D.Ptnr**	**First Name**	**Last Name (if different)**	**Date of Birth**

Member's Signature _____ **Date Signed** _____

Unmarried, dependent children ages 19 to 25 are eligible for benefits only if they are full time students and proof is received in our office. Unmarried children 19 years of age or older who are incapable of self-support because of mental or physical disability are covered provided the disability began before the age of 19. A special form is required for disabled children and is available from the **Benefit Trust Fund Office.**

CHILDREN / DEPENDENTS

First Name	**Last Name (if different)**	**Daughter**	**Son**	**Date of Birth**

NOTE: Members who defraud or attempt to defraud the FUND or who knowingly give false or misleading information are subject to a penalty which may include suspension of eligibility for all FUND benefits. Members are responsible for notifying the FUND Office of any changes in marital and/or dependent status by submitting a Change of Status Card, which is available from the fund office. 1/19