PLEASE RETAIN TOP PORTION FOR YOUR RECORDS

This change form is for the UUP Benefit Trust Fund. The Fund provides coverage for dental, vision and a tuition scholarship program for UUP members and agency fee payers in the Bargaining Unit who are eligible for the New York State Health Insurance Program under the UUP/State collective bargaining agreement.

This form must be completed to make a dependent change or correction. This form may also be used to report a change of address. 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.

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

THIS IS NOT AN ENROLLMENT CARD

Please note that a copy of a valid marriage certificate or birth certificate is required for newly added dependents

Please print in ink
Be sure to sign

Change of Marital or Dependent Status ONLY

800-UUP-FUND
800-887-3863

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

Name (Last, First, Middle Initial) **SS # (Optional)**

_____ _____

Home Address Number and Street City State Zip Code **Work Phone** **Home Phone**

_____ _____

CHANGE OF MARITAL STATUS OR NAME CHANGE (*Contact your HBA to add/delete a Domestic Partner)*

☐ I have been married; please add the name of my spouse. Date Married _____

Spouse's Name _____ SS # (Optional) _____ Birth Date _____

☐ I have divorced ☐ I am widowed Date of Event _____

Delete Name of Spouse _____

NAME CHANGE

☐ New Name _____ Former Name _____

Must Sign X _____ _____

Member Signature *Date*

Change of Dependents

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

☐ Add name(s) of child(ren) on chart below.

☐ Delete name(s) of child(ren) on chart below. Delete Date _____

SS # (optional)	NAME Last *(only if different)* First, Middle Initial	Wife	Husband	Daughter	Son	Birth Date	Full Student (*Proof Required)*