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

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

800-UUP-FUND
800-887-3863

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)*