United Benefit Fund

40-26 235th Street

Douglaston, NY 11363

Tel: 1-877-226-2829/Fax:718-559-6489

info@unitedbenefitfund.com

Health Plan Enrollment Form

Employer/Shop Name: ________________

Submitted to UBF By: ________________

Coverage Start Date: ________________

PLEASE FILL CLEARLY All REQUIRED INFORMATION

LAST NAME: ______________________________ FIRST NAME: ______________________________

ADDRESS: ____

CITY: ________________ STATE: __________ ZIP: __________ EMAIL: ______________________

SOCIAL SECURITY NUMBER: ______________________________ DATE OF BIRTH: ________________

PHONE NUMBER: ______________________ MARITAL STATUS: ☐ SINGLE ☐ MARRIED SEX: ☐ MLE ☐ FEMALE

WHO WAS YOUR PREVIOUS INSURANCE CARRIER?

CARRIER NAME: ________________ TEL: ____________ POLICY #: ____________ TERM DATE: ____________

DO YOU (OR SPOUSE/DEPENDENT) HAVE COVERAGE WITH MEDICARE/MEDICAID OR ANY OTHER HEALTH INSURANCE?

☐ YES ☐ NO If YES, WHO? ____

CARRIER NAME: ________________ TEL: ____________ POLICY #: ____________ TERM DATE: ____________

***If you are applying for coverage for your spouse and/or children, please list each one below-see election of coverage for eligibility. If electing spousal/dependent coverage please furnish all appropriate marriage/birth/adoption certificates at the time of enrollment for anyone with a different last name than the primary**

RELATIONSHIP (husband/wife son/daughter)	**LAST NAME** ex: SMITH	**FIRST NAME** ex: JOHN	**SOCIAL SECURITY NUMBER** ex: 123-45-6789	**SEX** M/F	**BIRTH DATE** ex: 12/25/1990	**CHICK IF DISABLED**

ELECTION OF COVERAGE AND AUTHORIZATION*

- The applicant in consideration of participation in the plan hereby consents to indemnify and hold harmless the third-party administrator, its agents, owners, successors and/or assigns for any claims that may arise by the participation of the plan.
- I am applying for coverage for myself, my spouse, and any eligible unmarried children between the ages of 19 and 26 who does not have access to other coverage. I elect to enroll myself and my family members, if any, with the Medical Group/Network Physicians associated with the United Benefit Found.
- I understand that I may be asked to recertify my adult dependent status once per year.
- On behalf of myself and each eligible Family Member, I hereby authorize all physicians, nurses, hospitals and other providers who or which have at any time either before or after we become covered by U.B.F., provided any diagnosis, treatment, or any other service to any of us, to furnish to U.B.F. and our Medical Group/Network Physician all information and records relating thereto.
- If I am required to contribute the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due to me and remit same to U.B.F.
- All information provided above is true and complete to the best of my knowledge. A copy of this application will be placed in my U.B.F. medical record.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading. Information concerning any fact…thereto commits a fraudulent insurance act, which is a crime, shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.
- All applicants must sign below. Any false statement will be cause for immediate cancellation of coverage.

APPLICANT MUST SIGN HERE: ______________________________ TODAY'S DATE: ________________