CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK
WELFARE TRUST FUND
ENROLLMENT FORM
PLEASE COMPLETE AND RETURN TO

ADMINISTRATIVE SERVICES ONLY, INC.
303 MERRICK ROAD, SUITE 300 Dept 150
LYNBROOK, NY 11563
516-396-5500

☐ **NEW MEMBER** ☐ **CHANGE OF ADDRESS** ☐ **NEW DEPENDENT INFORMATION**

ELIGIBILITY STATUS: ☐ **ACTIVE-FULLTIME** ☐ **ACTIVE PART-TIME** ☐ **RETIREE**

DATE HIRED AS A COURT ATTORNEY
COVERED UNDER TITLES REPRESENTED BY CALA:_____/_____/_____

Active and Part-Time Employed members may decline coverage of the Fund benefits (Dental and Vision) for themselves and/or any enrolled dependents at any time by completing the Declination of Coverage form which is available at www.nyscala.com

SECTION I MEMBER INFORMATION

SOCIAL SECURITY NUMBER				DATE OF BIRTH
☐☐☐-☐☐-☐☐☐☐				☐☐/☐☐/☐☐
LAST NAME	**FIRST NAME**	**MI**		
ADDRESS	**APT NO.**	**CITY**	**STATE**	**ZIP**

GENDER: ☐ **MALE** ☐ **FEMALE** **MARITAL STATUS:** ☐**SINGLE** ☐**MARRIED** ☐**DIVORCED** ☐**SEPARATED**

PHONE DAY: **EVENING:** **EMAIL ADDRESS**

ARE YOU, YOUR SPOUSE OR DEPENDENT CHILDREN COVERED BY ANOTHER

DENTAL BENEFIT PROGRAM? ☐ **YES** ☐ **NO** **OPTICAL BENEFIT PROGRAM?** ☐ **YES** ☐ **NO**

Notice of HIPAA Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents.

To request special enrollment or obtain more information, contact the Welfare Fund Office at 1-516-396-5500.

SECTION II MEMBER SIGNATURE

I HEREBY CERTIFY THAT ALL THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A DENIAL OR SUSPENSION OF BENEFITS. IN ADDITION, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR THE FUND OR FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

MEMBER'S SIGNATURE:_____ **DATE:**_____/_____/_____

SECTION III ☐ **SPOUSE - PLEASE ATTACH COPY OF MARRIAGE CERTIFICATE OR YOUR NYSHIP CARD LISTING YOUR SPOUSE AND DEPENDENTS**

☐ **DOMESTIC PARTNER – PLEASE CONTACT ADMINISTRATIVE SERVICES ONLY, INC FOR A DOMESTIC PARTNER ENROLLMENT FORM**

SOCIAL SECURITY NUMBER	DATE OF BIRTH
☐☐☐-☐☐-☐☐☐☐	☐☐/☐☐/☐☐

FIRST NAME	LAST NAME	MI

IS SPOUSE/DOMESTIC PARTNER EMPLOYED? ☐ **YES** ☐ **NO IF YES, EMPLOYER NAME:**_____

DOES THIS EMPLOYER PROVIDE COVERAGE FOR	IF YES, PLEASE PROVIDE NAME OF INSURANCE COMPANY
DENTAL? ☐ **YES** ☐ **NO**	
OPTICAL? ☐ **YES** ☐ **NO**	

SECTION IV **DEPENDENT CHILD INFORMATION** - COPIES OF BIRTH CERTIFICATES, ADOPTION CERTIFICATES, PROOF OF LEGAL GUARDIANSHIP OR YOUR NY SHIP CARD WITH YOUR DEPENDENT CHILD'S NAME MUST BE ATTACHED.

This coverage is available even if the child is eligible to enroll in another employer sponsored plan. This means even if a child was offered and or is covered by his or her own employer, or his or her spouse's employer, then the parent's plan is still required to continue dependent coverage to age 26.

NAME	DATE OF BIRTH	SOCIAL SECURITY NO.
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