MEMBER BENEFITS
nysut
Working to Benefit You

CATASTROPHE MAJOR MEDICAL PLAN

Sponsored by NYSUT Member Benefits Catastrophe Major Medical Insurance Trust

CHANGE FORM

INSTRUCTIONS

1. Fully complete the appropriate sections and sign in the space provided.
2. Mail your completed form to: Association Member Benefits Advisors
   PO Box 9186
   Des Moines, IA 50306-0362

PLEASE NOTE:

- Requests to add Spouses/Dependents must be requested within **60** days after the life event.
- All eligible NYSUT members and dependents must be covered by or insured under a Basic Plan*.

Questions? **Call Association Member Benefits Advisors (AMBA) at 888-386-9788.**

NYSUT MEMBER INFORMATION

NYSUT ID#	Last Name	First Name	
Home Address (Street)			Apt
City	State	Zip	Phone Number
Is this a new address? Yes ☐ No ☐	E-mail		

GENERAL CHANGES

☐ Name Change	Previous Last Name (If different)	Previous First Name (If different)
☐ I hereby request cancellation of my coverage for myself and all dependents.		

ADD SPOUSE/DEPENDENTS

☐ Spouse/Domestic Partner (DP)	Name (Last, First)	Date of Birth
Is this person covered by a Basic Plan*? Yes ☐ No ☐		
☐ Child	Name (Last, First)	Date of Birth
Is this person covered by a Basic Plan*? Yes ☐ No ☐		
☐ Child	Name (Last, First)	Date of Birth
Is this person covered by a Basic Plan*? Yes ☐ No ☐		

IMPORTANT:

- If space is not adequate, use a separate page that lists the name, date of birth, relationship and answer to the Basic Plan* question.
- Children must be under the age of 30 and covered by or insured under a Basic Plan* to be enrolled.
- PROOF OF DEPENDENT STATUS IS REQUIRED: Requests to add dependents must include a copy of supporting documentation. (e.g. marriage license, birth certificate, completed Domestic Partner Affidavit (available online) with supporting documents or other applicable documents as indicated in the CMM Plan Document.)

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REMOVE SPOUSE/DP/DEPENDENT		Date of Event mm/dd/yy	Spouse/DP/Dependents Name Last, First
	Death of: ☐ Spouse/DP ☐ Dependent		
	☐ Divorce ☐ DP Relationship End		
	☐ Other		

***Basic Plan** means any and all of the following health related Plans in which an eligible participant is enrolled:

- New York State Health Insurance Program's Empire Plan (NYSHIP);
- New York City Health Insurance Program (NYC);
- Plan offered by Member's Employer (e.g., Article 47/Consortium plan, Article 43 plan or employer-sponsored plan) that provides Minimum Essential Coverage and Minimum Value within the meaning of the Affordable Care Act;
- Other group health plan, including the group health plan of a spouse or dependent, that provides Minimum Essential Coverage and Minimum Value within the meaning of the Affordable Care Act; or
- For Medicare-eligible participants, Parts A and B or Part C (Medicare Advantage Plan).

You must have basic prescription drug coverage in order for prescription drug benefits to be payable. If a participant is a Medicare-primary beneficiary, he or she must be enrolled in a Part D Plan or have Creditable prescription drug coverage (as defined by Medicare) through another Basic Plan. No benefits for prescription drugs will be payable under this Plan for individuals who are not enrolled in a prescription drug program.

A Basic Plan does not include:

- An individual Plan either purchased on or off any state/federal Marketplace/Exchange;
- Medicaid;
- A State Children's Health Insurance Plan (CHIP); or
- TRICARE.

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurer or self-insurer in connection with an application for insurance or statement of claim that contains any false or incomplete information commits a fraudulent act that may be a crime and may subject such person to incarceration, fines and denial of benefits. Coverage may be retroactively terminated if such fraud is discovered.

Member's Signature _____ **Date** _____

Mail this form to: Association Member Benefits Advisors, PO Box 9186, Des Moines, IA 50306-0362

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IMPORTANT

Remember to:

- Sign and date the form; and
- If adding a spouse/domestic partner or dependent:
  - Provide proof of dependent status.