



2 Hamilton Avenue, New Rochelle, New York 10801

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WWW.NRFUSE.ORG

FEDERATION OF UNITED SCHOOL EMPLOYEES

N.Y.S.U.T. - A.F.T. Local 280 - A.F.L. - C.I.O.

**OPEN ENROLLMENT  
FOR EMPLOYEES WHO DO NOT PRESENTLY  
HAVE DEPENDENT DENTAL COVERAGE**

- 1) Any employee hired on or before September 1, 2008, who does not presently have dependents' coverage, may enroll by completing the enclosed form by September 22, 2008.
- 2) Any employee hired after September 1, 2008, who does not presently have dependents' dental coverage, may enroll by completing the enclosed form within 30 days of their date of hire.

**THERE WILL BE NO FURTHER OPPORTUNITY TO ENROLL FOR DEPENDENTS' COVERAGE UNTIL SEPTEMBER 2009.**

All payroll deductions for dependents' coverage will commence with the first paycheck after enrollment (no earlier than the October 15, 2008 paycheck) and continue through the June 26, 2009 paycheck (maximum 18 pay periods). There will be no deductions during the month of September 2008.

Using the multi-rate system, you can select the rate by choosing only those dependents you wish to cover: Again, your payment will be payroll deducted through the June 2009 paychecks. Please see the rate schedule below.

**PLEASE NOTE:** *Prostodontics and orthodontic benefits are payable only if insurance has been in force for 12 consecutive months with respect to the individual(s) incurring expense. (See pp 10-11 of the Benefit Booklet. The only exception to this rule is found on P. 10 # 6 (a + b).*

Please return the completed authorization to the F.U.S.E. Welfare Fund Office, 2 Hamilton Ave., Rm 201, New Rochelle, NY 10801 - **NO LATER THAN 30 days after initial hire.** Upon receipt of your enrollment form, we will send you a confirmation of your request at your work location.

**WHETHER OR NOT YOU DECIDE TO GET SPOUSAL/DEPENDENT COVERAGE, YOU MUST SIGN AND RETURN THIS FORM TO FUSE IN THE ENCLOSED ENVELOPE VIA THE PONY.**

**2008-2009 SELF-PAY DEPENDENT COVERAGE RATES**

<u>CATEGORY</u>	<u>ANNUAL COST</u>	<u>PAYROLL DEDUCTION</u>
SPOUSE	\$399.00 (maximum)	<u>18 pay periods</u> (maximum)
EACH DEPENDENT CHILD	\$258.30 (maximum)	\$22.17 \$14.35

I would like to apply for spousal/dependents coverage. I have enclosed the appropriate form.

I decline spousal/dependents coverage.

Name (PRINT) \_\_\_\_\_ Signature \_\_\_\_\_





NEW ROCHELLE F.U.S.E. WELFARE FUND  
**2008-2009 DEPENDENT ENROLLMENT FORM**

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**EMPLOYEE INFORMATION (PLEASE PRINT)**

\_\_\_\_\_  
Last Name                      First Name                      M.I.                      Social Security #                      School / Location

\_\_\_\_\_  
ADDRESS: No. and Street                      City                      State                      Zip

\_\_\_\_\_  
Date of Birth                      Telephone No.                      Date

Marital Status:     Single             Married             Divorced             Legally Separated

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**DEPENDENTS' INFORMATION (PLEASE PRINT)**

Please only list information for a spouse and/or dependents that you wish to have covered.

**All information (including Social Security numbers) must be supplied before coverage for spouse or dependents can be activated.**

**SPOUSE**

\_\_\_\_\_  
Last Name                      First Name                      M.I.                      Social Security #                      Date of Birth

Is spouse covered by another plan?     Yes     No    If yes, please name other plan \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

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**DEPENDENT CHILDREN (PLEASE PRINT)**

**LEGALLY ELIGIBLE CHILDREN TO BE COVERED:**

	<u>Name</u>	<u>Social Security #</u>	<u>Relationship</u>	<u>Date of Birth</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Are dependent children covered by another plan?     Yes     No

If yes, please name other plan \_\_\_\_\_

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By signing this enrollment form, you are acknowledging that you understand that: 1) funds will be deducted from your paychecks during the months of October through and including June; 2) that this is an opt-out plan. Funds will be deducted every year until you notify us of any additions or deletions.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_