PLEASE RETAIN TOP PORTION FOR YOUR RECORDS

All employees in the UUP Bargaining Unit may maintain dental and vision benefits through the UUP Benefit Trust Fund (Fund) on a direct-payment basis if: (**one of the following apply**)

- They are placed on an authorized leave without pay, regardless of the type of leave they have been granted. Employees may maintain direct-payment coverage for the full duration of their authorized leave.

OR

- They are employed, but do not meet the requirements to be eligible for New York State Health Insurance Program (NYSHIP) coverage. Fund benefits can be purchased on a direct-payment full-share basis as long as the employee remains employed.

OR

- They are retrenched and placed on a preferred list. Employees may maintain direct-payment coverage for up to 12 consecutive months or until they are re-employed in a benefits-eligible position by a public or private employer, whichever occurs first.

In order to maintain benefits, the member must notify the Fund Office within **60 days** of Fund coverage ending.

Date Signed and Mailed:__________________

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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

Please Print in Ink and Sign

Direct Payment Application

UUP Benefit Trust Fund
P.O. Box 15143, Albany, NY 12212-5143
800-887-3863 or 800-UUP-FUND

Name (Last, First, Middle Initial) Phone # SS # (Optional)

___

Home Address – Number & Street City, State, Zip Code

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Date of Birth ______/______/______ Last Date on N.Y.S. Payroll ______/______/______

Coverage Requested: ☐ Individual ☐ Family **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

List below, the names of spouse/domestic partner (domestic partner information must be provided to your **campus benefits office**) and unmarried children under 25 years of age. Unmarried, dependent children ages 19 to 25 are eligible for benefits only if they are full time students. Unmarried children 19 years of age or older, who are incapable of self support because of mental or physical disability are covered provided that the disability began before the age of 19.

SS # (optional)	First Name, MI, Last Name (if different)	Relationship	Student	Date of Birth

See Reverse Side **Effective Date** ___/____/___ (For Fund Use Only)

Complete and return this application to the FUND office no later than thirty days after your Fund coverage has terminated.

I hereby request to continue my UUP Benefit Trust Fund coverage on a direct payment basis. I agree to pay each installment of the premium due in advance of the start of each period.

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Member's Signature **Date**