

## Mail, Fax or Email completed form to:

UUP Benefit Trust Fund, P.O. Box 15143, Albany, NY 12212-5143 800-887-3863 (Phone) 866-559-0516 (Fax)

Email: benefits@ uupmail.org

## **Change of Marital or Dependent Status**

A copy of a valid marriage certificate or birth certificate is required.

EMPLOYEE INFORMATION

Name (Last, First, Middle Initial)				NY State Employee ID			
Home Address Number and Street		City		State, Zip Code			
Work Phone		<b>Home Phone</b>					
MARITIAL STA	TUS CHANGE						
☐ I am married	□ Male	☐ Female					
Name of Spouse		Date Married		Date of Bir	rth		
☐ I am divorced	□ I am wide	owed					
Delete Name of Spouse		Date of Event					
DOMESTIC PAI	RTNER CHANGE						
☐ Add  Name of Domestic	□ Delete Partner	Date of Event	. for eligibili	v verification. Tl	ne Fund car	nnot enroll	
☐ Add  Name of Domestic  *Domestic Partner domestic partners to	☐ Delete  Partner  information must be proviuntil confirmation has been ants only dental & vision of	ded to the campus HBA n received from the NYS	Dept. of Civ	il Service. Please			
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Rev. 3/15/19