



Environmental Police Benevolent Association Benefits Fund (EBF)

708 E Chester Street, 2nd Floor, Kingston, New York 12401 * WWW.EPBA.US * Tel: 845-202-0372

APPLICATION FOR TRANSITIONAL MEMBERSHIP

For Union Dental, Union Vision, Union Life insurance, and Union Prescription Plan Benefits

Instructions for Completing EBF Application for Transitional Membership

- I. Member must complete the application each time this form is submitted. New members must attach relevant documentation (government-issued marriage certificates, birth certificates, domestic partner certification letters from The Employee Benefits Program, etc.). Current members must attach relevant documentation if dependents are added.
- II. Complete **Member Information**.
- III. **Eligible Dependent Information.** List all eligible dependents to be covered under your EBF benefits. Please attach relevant documentation (marriage certificate, birth certificate, or domestic partner certification). If there are more than four children, please attach another piece of paper with the required information and include the member's name, date, and signature. Under the Internal Revenue Service (IRS) Ruling, if your domestic partner is not a dependent within the meaning of the Internal Revenue Code (IRC), the amount paid by the Fund attributable to coverage of a Fund member's domestic partner is treated as part of the Fund member's gross income from City employment for Federal tax purposes. State and local tax treatment of the amount in question may vary among jurisdictions for a domestic partnership.
- IV. **Basic Life* Insurance Designation of Beneficiary.** Each EBF member is issued Basic Life insurance. The amount for which each member is covered is determined by employment status (active or retiree), Levels of coverage are as follows:

Active Employees (64 years and under)	1 time (1X) \$25,000
Retiree	1 time (1X) \$25,000

Indicate your Basic Life Insurance Primary and Contingent beneficiary(ies) and their Social Security Number, address, relationship, and whether they are primary (p) or contingent (c). You may designate multiple primary beneficiaries, but the total percentage for your primary beneficiaries must equal 100%. You may also designate more than one contingent beneficiary, but the total percentage for your contingent beneficiaries must equal 100%.

- V. **Member Signature.** Sign and date this section.
- VI. **Union Association Certification.** The Union Association Personnel is responsible for certifying your EBF Transitional Membership eligibility and submitting your complete application to EBF. You will receive a confirmation email or letter once EBF certifies and processes your application. Please make a copy for your records.

Should you have any questions regarding EBF membership, don't hesitate to contact your EPBA Union Admin or the EPBA Union Office at 845-663-1865. For the most updated information on EBF benefits, please visit the EPBA Web site at www.epba.us

*The insurance carrier issues Group Basic Life coverage.

**PLEASE EMAIL ALL DOCUMENTS DIRECTLY TO
PBAADMIN@EPBA.US**



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I. PLEASE COMPLETE ENTIRE APPLICATION. SEE REVERSE SIDE FOR INSTRUCTION

☐ ENROLLMENT: CHECK ONE ☐ ACTIVE ☐ RETIRED

- ☐ SPOUSE ☐ ADD ☐ DROP EFFECTIVE DATE: _____ ATTACH MARRIAGE CERTIFICATE
- ☐ DOMESTIC PARTNER ☐ ADD ☐ DROP EFFECTIVE DATE: _____ ATTACH CITY HEALTH PROGRAM DOMESTIC PARTNER CERTIFICATION LETTER
- ☐ DEPENDENT CHILDREN ☐ ADD ☐ DROP EFFECTIVE DATE: _____ IF ADDING A CHILD, ATTACH COPY OF THE BIRTH/ADOPTION CERTIFICATE
- ☐ CHANGE OF NAME EFFECTIVE DATE: _____ ATTACH RELEVANT DOCUMENTATION
- ☐ TRANSFER FROM ANOTHER AGENCY EFFECTIVE DATE: _____ FORMER AGENCY: _____
- ☐ CHANGE OF BASIC LIFE INSURANCE BENEFICIARY

* MUST ATTACH RELEVANT DOCUMENTATION (REFER TO INSTRUCTIONS ON THE BACK OF THIS FORM)

II. MEMBER INFORMATION

LAST NAME:		FIRST NAME:		MI:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
SOCIAL SECURITY NUMBER:		MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGAL SEPARATION <input type="checkbox"/> DIVORCED <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> WIDOWED			DATE OF BIRTH:
HOME ADDRESS (NUMBER AND STREET):					APT:
CITY:				STATE:	ZIP CODE:
AGENCY NAME/AGENCY RETIRED FROM: CITY NEW YORK DEPT. OF ENVIR PROTECTION POLICE DEPT. / NYC DEP PD			HOME TELEPHONE NUMBER:	OFFICE TELEPHONE NUMBER: 718-595-3000	

III. ELIGIBLE DEPENDENT INFORMATION (CHILDREN ARE ELIGIBLE UP TO 26 YEARS)

LAST NAME (IF DIFFERENT)	FIRST NAME	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER				
CHILD / OTHER				
CHILD / OTHER				
CHILD / OTHER				
CHILD / OTHER				
CHILD / OTHER				
CHILD / OTHER				

IV. BASIC LIFE INSURANCE BENEFICIARY DESIGNATION — INDICATES WHETHER THE BENEFICIARY IS PRIMARY (P) OR CONTINGENT (C)

NAME	SOCIAL SECURITY NUMBER	ADDRESS	RELATIONSHIP	(P) OR (C)	PERCENTAGE

I have attached a signed, separate sheet listing additional beneficiaries: ☐ YES ☐ NO

V. MEMBER SIGNATURE

I wish to enroll or effect the changes noted above in the EPBA Benefit Fund. I affirm that the information/documentation is accurate and complete.

MEMBER SIGNATURE:

DATE:

VI. AGENCY TITLE CODE AND NAME INFORMATION

AGENCY CODE: 0826	TITLE CODE NUMBER: 70811	TITLE NAME: Environmental Police Officer	PHONE NUMBER: 845-202-0372
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