SUNY RF
The Research Foundation for
The State University of New York
Office of Human Resources, Benefits Services

Young Adult Election and Eligibility Form

For Use When Covered Employee or Child ("Young Adult") Exercises Right of Election to Extend Young Adult Coverage through Age 29

Employees covered under group health insurance policies issued in New York State, and their eligible children, may purchase extended coverage for the children through age 29. To qualify for the extended coverage, the child (Young Adult) must meet each of the eligibility requirements listed below.

The Young Adult coverage will be the same as for the employee covered under the Research Foundation for the SUNY group policy. **The additional premium due with respect to the extended Young Adult coverage is solely the responsibility of the employee or the young adult.**

DIRECTIONS:

Provide the following information in full and **submit the signed form** to the RF central office benefits services unit at the address on the other side of this form. In all cases, an enrollment form for the PPO or HMO health plan must also be completed to extend coverage for the dependent. Use one form for each person electing coverage.

MEMBER AND GROUP INFORMATION

_____ _____
Member Name (RF Employee) RF Identification Number (Employee # or SSN)

_____
Health Plan Name

CHILD / YOUNG ADULT INFORMATION

_____ _____ _____ _____
Last Name First Name MI Date of Birth (mm/dd/yyyy)

_____
Dependent Address

_____
Relationship to Employee

-- PLEASE SEE OTHER SIDE –

ELIGIBILITY REQUIREMENTS:

The employee or dependent must answer **YES** to **EACH** of the Following Statements for the young adult to Qualify:

The young adult is:

The unmarried child of the employee insured under the policy	_____YES
Under age 30	_____YES
Not covered by, or eligible for, his or her own employer-sponsored insurance	_____YES
Not covered under Medicare	_____YES
Lives, works or resides in New York State or in the coverage area of the insurance carrier	_____YES

ACKNOWLEDGEMENT OF PREMIUM PAYMENT OBLIGATION

I understand and agree that I will be fully responsible for payment of the additional premium due with respect to the extended young adult coverage being requested hereby, which may not exceed 100% of the single premium rate.

If signing as the employee, I hereby certify that I am eligible for coverage under the group policy listed above.

I hereby certify that the above statements regarding eligibility for myself and my child are complete and correct to the best of my knowledge.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____

Signature of Employee or Young Adult Date

_____

Print Name

Please send the completed forms to:

The Research Foundation for SUNY
Benefits Services Unit
35 State Street
Albany, NY 12207