

**PLEASE RETAIN TOP PORTION FOR YOUR RECORDS**

This change form is for the UUP Benefit Trust Fund (BTF). The Fund provides dental and vision coverage for members of the Professional Services Negotiating Unit (PSNU) who are eligible for the New York State Health Insurance Program (NYSHIP) under the UUP/State collective bargaining agreement.

This form must be completed to make a dependent change or correction. This form may also be used to report a change of address. Completion of this form does not imply eligibility. You may verify eligibility for the UUP Benefit Trust Fund by calling the Fund Office at (800) 887-3863.

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

**THIS IS NOT AN ENROLLMENT CARD**

**Please note that a copy of a valid marriage certificate or birth certificate is required for newly added dependents**

*Please print in ink  
Be sure to sign*

**Change of Marital or Dependent Status ONLY**

**800-UUP-FUND  
800-887-3863**

UUP Benefit Trust Fund  
P.O. Box 15143, Albany, NY 12212-5143

Name (Last, First, Middle Initial) \_\_\_\_\_

NY State Employee ID \_\_\_\_\_

Home Address Number and Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

**CHANGE OF MARITAL STATUS OR NAME CHANGE** (Contact your HBA to add/delete a Domestic Partner)

- I have been married; please add the name of my spouse. Date Married \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Birth Date \_\_\_\_\_
- I have divorced  I am widowed Date of Event \_\_\_\_\_  
 Delete Name of Spouse \_\_\_\_\_

**NAME CHANGE**

- New Name \_\_\_\_\_ Former Name \_\_\_\_\_

**Please Sign X** \_\_\_\_\_

*Member Signature*

*Date*

**Change of Dependents**

UUP Benefit Trust Fund  
P.O. Box 15143, Albany, NY 12212-5143

- Add name(s) of child(ren) on chart below.  
 Delete name(s) of child(ren) on chart below. Delete Date \_\_\_\_\_

	NAME Last (only if different) First, Middle Initial	Wife	Husband	Daughter	Son	Birth Date	Full-Time Student (Proof Required)

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