



WELFARE FUND

52 Broadway
New York, NY 10004

**Application To Purchase
Age 29 Young Adult Coverage
UFT Welfare Fund Benefits Only**

(This Application is not used for Medical & Hospital Coverage)

- INSTRUCTIONS:**
- 1 - Complete a separate Application For Young Adult Coverage for each dependent child between the ages of 26 and 29 for whom you are requesting UFT Welfare Fund coverage.
 - 2 - Complete a UFT Welfare Fund Change Of Status form (online at www.uftwf.org or a manual paper form) in order to enroll your dependent child with the UFT Welfare Fund.
 - 3 - Send a copy of your child's birth certificate along with this completed form, signed by the member.
 - 4 - Your first month premium must be enclosed along with this completed form
 - Dependent Children of In-Service Members: **\$67.35** per child, per month
 - Dependent Children of Retired Members: **\$23.35** per child, per month

PLEASE NOTE: In order to be eligible under the NYS Age 29 Coverage Expansion, your dependent child

- MUST:**
- * - Be unmarried, and
 - * - Be age 29 or younger, and
 - * - Live, work, or reside in NY State or the health insurance company's service area, and
 - * - Not be covered by Medicare, and
 - * - Not be insured, or eligible for comprehensive health insurance through his/her employer.

*** Coverage begins the first day of the month following receipt of this application. ***

Must Be Completed By Member:

Member's Name : _____	Welfare Fund Alt. ID # or Soc. Sec. # : _____
Address : _____	File # : _____
City, State, Zip : _____	Telephone # : _____

Dependent Child's Name : _____	Dependent Child's Date of Birth : _____
Relationship to Member : _____	Dependent Child's Soc. Sec. # : _____
Address (if different from Member): _____	Telephone # : _____
City, State, Zip : _____	

Is your Dependent child currently employed: Yes
 No

If yes, please provide the following information regarding your dependent child:

Employer's Name : _____

Employer's Address : _____

City, State, Zip : _____

Employer's Telephone # : _____

ATTESTATION: Health coverage is not available from my dependent child's employer.

Signature of Member : _____ Date : _____