SECURITY BENEFIT FUND
OF THE
UNIFORMED FIREFIGHTERS ASSOCIATION

OF GREATER NEW YORK • LOCAL 94 I.A.F.F. AFL-CIO

204 EAST 23rd STREET, NEW YORK, N.Y. 10010
TEL: (212) 683-4723 • FAX: (212) 683-0693
Web Address: www.ufanyc.org Email: SBFStaff@ufanyc.org

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IMPORTANT NOTICE REGARDING SECURITY BENEFIT FUND
BENEFITS FOR DEPENDENTS AGED 19-26 YEARS OLD

June 1, 2011

Dear Member:

Under the Federal health care reform law, the Patient Protection and Affordable Care Act (PPACA), health plans that cover dependent children must continue to make dependent health coverage available until a child turns age 26. Generally, the requirement applies only to medical coverage. However, the Security Benefits Fund has decided to extend coverage for all of the benefits provided through the Fund.

- If you do **NOT** have a dependent between the ages of 19-26, please **DISREGARD** this mailing.

- If you do have a dependent who is between the ages of 19-23 AND is a full-time College Student who has verified their full-time status with SBF this semester, they will automatically be rolled over to continue benefits to age 26. **You do not have to return the enclosed application**.

It is important to note that to be eligible for this extended coverage under the Security Benefits Fund your child must not be eligible for health coverage from his or her employer. In addition, he or she must meet the definition of "children" under the City's Health Benefit Program, which follows:

Effective July 1, 2011 the term "children" means the following:

a. natural children;
b. children for whom a court has accepted a consent to adopt and for the support of whom an employee or retiree has entered into an agreement;

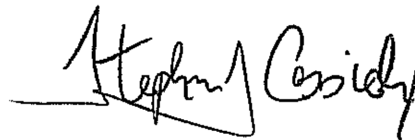
CONTINUED ON OTHER SIDE →

c. children required to be covered under a qualified medical child support order until the court order expires, at which time the child may continue to be eligible for coverage under (a) or (b) above;
d. children for whom a court of law has named the employee or retiree as legal guardian;
e. any other child who lives with an employee or retiree in a regular parent/child relationship and is the employee's or retiree's tax dependent. A child is the employee's or retiree's tax dependent if the employee or retiree claims the child on his/her income tax return as a dependent.
f. Unmarried children age 26 and older who cannot support themselves because of a disability, including mental illness, developmental disability, mental retardation or physical handicap are eligible for coverage if the disability occurred before the age at which the dependent coverage would otherwise terminate. Employees or retirees must provide medical evidence of the disability. The proof of disability must be submitted to the health plan within 31 days of the date the dependent reaches age 26. Eligibility for such dependents only applies to current employees whose disabled dependent children reach the age limitation while covered by a City health plan. New employees with disabled dependent children already over the age limitation may not include such children as dependents on their City health plan coverage. In addition, employees may not add disabled dependent children to their health plan coverage, if the child is already over age 26. Coverage will terminate for children reaching age 26 (other than eligible disabled children) at the end of the month in which the child reaches age 26.

If you are adding a dependent under the age of 26 who either lost coverage or was denied coverage based on his or her age, you will have **THIRTY DAYS from the date of this letter** to add him or her to your coverage to be effective July 1, 2011. **Please COMPLETE and return the attached form via fax at or USPS mail – the fax number and mailing address are noted on the form.**

If you have any questions or need more information, please call the Security Benefit Fund of the UFA at 212-683-4723.

Fraternally,



Stephen J. Cassidy
Chairman

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Attachment: Young Adult Dependent Coverage Application

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YOUNG ADULT DEPENDENT (19-26) COVERAGE APPLICATION

INSTRUCTIONS:

1. Complete this Application for Young Adult Coverage **FOR EACH DEPENDENT CHILD between the ages of 19 – 26** for whom you are requesting SBF (or RFSBF) Welfare Fund Coverage.
2. Please send this completed form, **SIGNED** and **DATED** by the member, to SBF.
   Form may be sent via fax or USPS mail (see above for fax number and / or mailing address).

PLEASE NOTE:

In order to be eligible under the Age 26 Coverage, your dependent child must:

- Meet the definition of "Children" under the City's Health Program (to see the definition, go to www.nyc.gov/olr, select "Health Benefits Program," click on "Summary Program Description" and go to page 3).
- Not be Eligible for Comprehensive Health Insurance through his/her employer.

SBF Benefits will be **effective STARTING on July 1, 2011.**

MUST BE COMPLETED BY MEMBER

MEMBER INFORMATION ☐ **ACTIVE** ☐ **RETIRED**

Member's Name: ______________________ Member Social Security #: ______________________

Address: ______________________ Member's Cell #: ______________________

City/State/Zip ______________________ Member's Home #: ______________________

Member Email Address: ______________________

DEPENDENT (19-26) INFORMATION

Dependent's Name: ______________________ Dependent's Social Security #: ______________________

Relationship to Member: ______________________ Dependent Child's Date of Birth: ______________________

Address (If Different than Member) ______________________ Dependent's Home #: ______________________

City/State/Zip ______________________ Dependent's Email Address: ______________________

Is your Dependent Child Currently Employed? ☐ YES ☐ NO

If YES, please provide the following information regarding your Dependent Child's Employer:

DEPENDENT CHILD – EMPLOYMENT INFORMATION

Employer's Name: ______________________ Employer's Telephone #: ______________________

Address: ______________________ Supervisor Email Address: ______________________

City/State/Zip ______________________

ATTESTATION: Health coverage is not available from my Dependent Child's Employer.

X Signature of MEMBER: ______________________ Date: ______________________

PLEASE NOTE: This form, including any attachments, may include privileged, confidential and/or inside information. Any distribution or use of this communication by anyone other than the intended recipient(s) is strictly prohibited and may be unlawful. If you are not the intended recipient, please notify the sender and destroy the original and any duplicates. Thank you.