Court Officers Benevolent Association
of Nassau County
Health and Welfare Fund

Return this form to:

COBANC Health and Welfare Fund
1 Old Country Rd
Ste 282
Carle Place NY 11514

ENROLLMENT / UPDATE FORM

Member Name

First Name	MI	Last Name

☐ **Initial Enrollment** ☐ **Updated Information**

Please See Instructions on Page 2

Member Information ☐ Active ☐ Retiree

SSN	Date of Birth: MM/DD/YYYY	Sex	Marital Status

Mobile Phone	Home Phone	Personal Email Address

Address	Apt/Suite/Other	City/Town	State	ZIP Code

Job Information

Title	Shield #	Title Date	COBANC Start Date	UCS Start Date	Veteran Status ☐ Yes ☐ No

Spouse ☐ Add ☐ Remove

First Name	MI	Last Name	SSN	Date of Birth: MM/DD/YYYY	Sex	Is Spouse Employed? ☐ Yes ☐ No

Employer Name	Address	City/Town	State	ZIP Code

Dependent Children ☐ Add ☐ Remove

#	First Name	MI	Last Name	**SSN**	Date of Birth: MM/DD/YYYY	Sex
1						
2						
3						
4						
5						

Primary Death Beneficiary

#	First Name	MI	Last Name	Address	Relationship	Percent
1						
2						
3						

Alternate Death Beneficiary

#	First Name	MI	Last Name	Address	Relationship	Percent
1						
2						
3						

I certify that the information provided is true and accurate, and that any sections left blank remain unchanged from information I have previously submitted. **Signature** _____ **Date** _____

YOU MUST SIGN AND DATE THIS FORM

INSTRUCTIONS

This form may be used for initial enrollment or updates.

It is preferable that you fill out this form electronically, then print, sign and date it before submitting it. If you hand-write this form, please print legibly.

Initial Enrollment vs. Updated Information.
If this is an initial enrollment, please complete the entire form.
If you are updating your information, you only need to enter the information that has changed (i.e. change of address, marital status, etc.).

Member Information. SSN is required for initial enrollment only. **Please indicate Active or Retiree** by checking the appropriate box.

Job Information. If this is an initial enrollment please enter all dates, even if they are the same.

- Title – Your official UCS title.
- Shield# - Enter only if applicable.
- Title date is the date you started in your current title.
- COBANC start date is the date you were assigned to the COBANC bargaining unit.
- UCS start date is the first date you worked for the Unified Court System.
- Retirement System start date is the first day you worked for any job in which you contributed to the NY State & Local Retirement System, not the date of your retirement.

Spouse. Please indicate whether you are adding or removing by checking the appropriate box.
If adding a spouse, **you must include proof of eligibility** (i.e. copy of Marriage Certificate or Affidavit of Domestic Partnership, etc.).
If removing a spouse, **you must include documentation** (i.e. Affidavit of Termination of Domestic Partnership or first page and signature page of Judgement of Divorce, etc.)

Dependent Children. Please indicate whether you are adding or removing by checking the appropriate box. If adding a child, **you must include proof of eligibility** (i.e. copy of Birth Certificate, Adoption Papers, etc.).

Death Beneficiary Designation (Please Clearly Designate All Primary and Contingent Death Beneficiaries)
Unless different percentages are indicated, the member death benefit will be divided equally among the Primary Beneficiaries. If no Primary Beneficiary survives the member, the benefit will pass to the Alternate Beneficiaries. If multiple beneficiaries are named, the percentage allocations must equal 100%.
No alterations are allowed in this section. Cross-outs or the use of white-out will void your beneficiary designation.

You must send this original signed and dated form, along with copies of proof of eligibility to:
COBANC Health and Welfare Fund
1 Old Country Rd
Suite 282
Carle Place NY 11514