



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