SUNY RF
The Research Foundation for
The State University of New York

INFORMATION UPDATE

Please complete and return this form in the enclosed postage paid envelope before January 1, 2015, ONLY if there has been a change in your personal information. If there are no changes to your personal information, you do not need to complete and return this form.

P L E A S E P R I N T

Name: _____

Social Security Number: _____

Current Address: _____

Phone Number and E-Mail Address_____

DEPENDENT INFORMATION

NAME OF DEPENDENT	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NO.

MEDICARE INFORMATION

Are you or your spouse covered under Medicare? If **no**, do nothing. If **yes,** please complete the following table. Mark Y or N in the appropriate box to indicate whether you have coverage and fill in the effective date of coverage.

NAME	MEDICARE PART A (Hospital) (Y / N)	MEDICARE PART B (MEDICAL/SURGICAL) (Y / N)	COVERAGE EFFECTIVE DATE.	
			PART A	PART B
(Self)			/ /	/ /
(Spouse)			/ /	/ /

If you have questions regarding coverage, claims, or policy changes, feel free to write or call Benefit Services at Benefits@rfsuny.org or (518) 434-7101.
Please RETURN TO:

The Research Foundation for SUNY
Office of Human Resources – 4th Floor
P.O. Box 9
Albany, NY 12201-0009

It is important if you have any changes to the above information in the future, to notify our office promptly. Thank you for your cooperation.