Excess Major Medical/Vision
Enrollment Card
(Please print all information)

Newman Co
925 Hempstead Tpke Ste 340
Franklin Square, NY 11010
516-488-1100

Policy Holder: Syosset Teachers' Association

Occupation: _____

Insured Name: (Last) _____ First: _____

Home Address: _____ City/State/Zip: _____

Date of Birth: _____ Date of Employment: _____

Social Security #: _____ Hours Worked Weekly: _____

Annual Salary: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Do you now have eligible dependents? ☐ Yes ☐ No

If yes, are they to be included in this plan? ☐ Yes ☐ No

If yes, please list your dependents below.

First Name	Date of Birth Month	Day	Year	Gender				
				M ☐	F ☐	Spouse
				M ☐	F ☐	Child
				M ☐	F ☐	Child
				M ☐	F ☐	Child
				M ☐	F ☐	Child
				M ☐	F ☐	Child
				M ☐	F ☐	Child

I AM APPLYING FOR:
☐ INDIVIDUAL or
☐ FAMILY COVERAGE /
DATE OF MARRIAGE_____

ELIGIBILITY: In order to be eligible for Excess Medical/Rehabilitation Insurance, you must be a participant in the empire NY State Government Employee Health Insurance program through either you or your spouse's employer. Check one:
____Own ____Spouse's **(Note you can still participate in the Vision Portion of the plan even if you do not participate in the Empire NY insurance plan)**

REQUEST TO PARTICIPATE

I hearby request the policy holder to arrange the issuance of group insurance to which I am entitled, or to which I may be entitled and I authorize my employer to make the periodic deductions, as applicable from my earnings as my contributions toward the cost of insurance.

Signed _____
Signature of Employee

Date _____

Primary Beneficiary:_____Relationship:_____
Address:_____
Contingent Benficiary:_____Relationship:_____
If more than one beneficiary is names, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the employee. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.