



Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Suite D
Bohemia, NY 11716-2540

SELF-PAY RETIREE BENEFITS PLAN ENROLLMENT FORM

Name: _____ **PIN:** _____

Address: _____

Phone Number: (____) _____ **Amount Enclosed:** _____

SELF-PAY RETIREE PLAN ELECTION: [] Premium [] Premium Plus [] Platinum

COVERAGE ELECTED: [] Individual [] Individual + 1 [] Family

COVERED DEPENDENTS:

I have received and reviewed the Fund's letter explaining the enhanced coverage available under the three self-pay retiree plans and elect to enroll in the Self-Pay Retiree Benefit Plan indicated above. I understand that this election is a commitment for plan participation for one (1) year. If, for any reason, I do not remit the required self-pay premium payment for any period of time during my participation, I understand that all Fund benefits will cease and I will not have the opportunity to enroll with the Benefit Fund as a retired plan member in the future in any retiree plan, including the no-cost plan.

(Signature) (Date)

Sworn to before me this
day of _____, 20__

NOTARY PUBLIC