International Union of Painters and Allied Trades

(IUPAT)

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District Council #4

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Glaziers Local #677

District Council #4

Michael Hogan
Business Manager Secretary Treasurer

Departments

Servicing	Organizing	Office Staff	Training	Trust Funds
Director	**Director**	**Fin. Secretary**	**Director**	**Manager**
Brian Lipczynski #660	Frank Stento	Heather Velie	Marc Braunstein	Sue Bernat
Business Reps	**Organizers**	**Admin**	**Coordinators**	**Benefits Admins**
Joe Comfort #677	Guy Falsetti	Judy Salansky	Bob Brueckman (WNY)	Velitchka Kireva
David Chaffee #150	Don Meyers	**Dues Admin**	Josh Osterhout (CNY)	Wendy Styn
Wesley Schlossin #43/#112	Joe Guza	Shannon Albano	**Staff**	Victoria Antonicelli
Dan LaFrance #31/#38			Kathy Velie	Nancy Haddad
Dan Jackson #11/#178			Hillary Sansone	

District Council #4/Glaziers Local #677
Information/Numbers

www.dc4.org

District Council #4 Headquarters:
585 Aero Drive
Cheektowaga, Ny 14225
Phone# (716) 565-0303

CNY Training Center
1875 Lorings Crossing
Cortlandville, Ny 13045

Business Manager: Michael Hogan
585 Aero Drive
Cheektowaga, NY 14225
mhogan@dc4.org

Dues: Shannon Albano
585 Aero Drive
Cheektowaga, NY 14225
Phone# (716) 565-0303
salbano@dc4.org

Funds Office: Wendy Styn
585 Aero Drive
Cheektowaga, NY 14225
Phone# (716) 565-0234
wstyn@dc4.org

Business Representative DC #4/ Local 677: Joe Comfort
6605 Pittsford Palmyra Rd E-6
Fairport, NY 14450
Phone# (585) 727-6228
jcomfort@dc4.org

Director of Organizing: Frank Stento
168 Susquehanna St
Binghamton, NY 13904
Phone# (607) 727-5208
fstento@dc4.org

District Council #4/Local #677
Information/Numbers

www.dc4.org

Apprentice Department
585 Aero Drive
Cheektowaga, NY 14225
Phone# (716) 565-0112

Director of Training and Apprenticeship: Marc Braunstein
mbraunstine@dc4.org

Apprentice Coordinators:
Josh Osterhout (CNY)
Phone# (607) 429-9401
josterhout@dc4.org
Bob Brueckman (WNY)
Phone# (585) 815-5112
rbrueckman@dc4.org

Apprentice Department Staff:
Kathy Velie
Kvelie@dc4.org
Hillary Sansone
hsansone@dc4.org

International Pension Office
7234 Parkway Drive
Hanover, MD 21076
Phone# 1-800-554-2479

Glaziers Local 677

www.dc4.org

Union Meetings are the first Monday of the Month @ 5pm

Rochester- In person 6605 Pittsford Palmyra Rd E-6 Fairport, NY 14450

Syracuse- Zoom link will be sent in a text message

Binghamton- Zoom link will be sent in a text message

Glazier Collective Bargaining Agreement
CBA

Glaziers Local 677

Social Media Information

Glaziers 677 Private Group

Glaziers 677 Instagram

GLAZIERS_LOCAL_677

Glaziers 677 Facebook page

TOOLS REQUIRED FOR THE GLAZING TRADE

The Glazing trade requires various tools, here is a list of tools you will need to perform your work. You will need to acquire more tools accordingly, but this is a good starting point in order of tools needed.

- Tool Bag
- Tape Measure (25’ is recommended)
- Utility Knife
- Tin Snips
- Mallett/Dead Blow
- Pry Bar (Jimmy Bar)
- Pruning Shears with Anvil
- Combination Square
- Speed Square
- Caulk Gun
- Caulking Tools
- Razor Scraper Handle
- Large Pry Bar (18” or 24”)
- Allen Wrench Sets (Standard & Metric)
- Vice Grips (Regular & Needle Nose)
- Torpedo Level
- Files
- Screwdriver Set
- Hack Saw
- Tool Belt

Glaziers Local #677

Rochester/Syracuse/Binghamton

International Union of Painters & Allied Trades, District Council #4

6605 Pittsford Palmyra Rd. Suite #E6, Town of Perinton (Fairport), NY 14450

Business Representative: Joe Comfort 585-727-6228

jcomfort@dc4.org

Ajay Glass & Mirror Co. Inc. 101 North Street Canandaigua, New York 14424 Phone: 585-393-0082 Fax: 585-393-0105 Contact: Jim Stathopoulos, President Email: jims@ajayglass.com or steves@ajayglass.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private	**Architectural Glass and Metal (AGM)** 3 Liebich Lane Clifton Park, New York 12065 Phone: 518-371-7007 Fax: 518-371-0767 Contact: Mike Haverly Email: info@agmglass.com Curtain Wall/Storefront/Pre-Glazed/Panels/NACC Public/Private
Binghamton Plate Glass 430 State Street Binghamton, New York 13902 Phone: 607-723-8293 Fax: 607-723-5561 Contact: Diane Emmi Email: bingplateglass@stny.rr.com dianebpg@stny.rr.com Curtain Wall/Light Commercial/ Public/Private	**BRG (Buffalo Road Glass)** 111 Buffalo Road Rochester, New York 14611 Phone: 585-235-8560 Fax: 585-235-5322 Contact: Gus Tamoutselis or Mike Bassett Email: gus@brgcorporation.com or mbassett@brgcorporation.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private
Davis-Fetch Glass 9 Lent Avenue Leroy, NY 14482 Phone: 585-649-9176 Contact: David Falk Email: dfalk@davisfetchglass.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private	**Forno Enterprises, Inc.** County Rd. #27 Trout Creek, New York 13847 Phone: 607-865-7860 Fax: 607-865-4392 Contact: Brian Albanese, President Email: brian@teamforno.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private
N.E.P. Glass Co. Inc. P.O. Box 277 6224 State Route 5 Little Falls, New York 13365 Phone: 315-823-8800 Fax: 315-823-2330 Contact: Jim Smith Email: jsmith@nepglass.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private & Residential	**Southern Glass Service** 3131 State Route 352 Big Flats, New York 14814 Phone: 607-562-3029 Fax: 607-562-3104 Contact: Rebecca Roe/Chris Dean/Jim Sherwood Email:rroe@southernglassservice.com cdean@southernglassservice.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private
	Utica Glass Company P.O. Box 528 Utica, New York 13503 Phone: (315) 732-5131 Fax: 315-732-2437 Contact: Gary Puleo Email: garypuleo@uticaglass.com or gp2@uticaglass.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private/Res.

D.C. #4's 16th Annual STAR Safety Awards

Date, Time & Place to be announced

STAR Raffle Requirements:

1. Must be a Member in good standing at the time of the Awards Ceremony.
2. Must be present at the 2023 Awards Ceremony.
3. Must complete a minimum of 800 "work hours" of employment for a signatory/signed employer during the Qualifying Period.
4. Must complete the Training Course requirements by the end of the Qualifying Period.

2023 STAR Course Requirements:

For each 16 hours of classroom//hands-on training you receive during the Qualifying Period in a **Qualifying Class** at the Finishing Trades Institute of Western & Central New York, (the "Training Fund"), you will be entitled to one chance in each prize category. You must complete and pass the course to receive credit towards the 16 hours. To receive a list of classes or enroll in a class, you should call (716) 565-0112 Monday through Friday, 8:00 a.m. to 4:30 p.m.

As an example: If you complete and pass a 32 hour classroom/hands-on training class, you will have (02) chances for the Grand Prize Raffle & (02) chances for the Primary Prize Raffle and (02) chances for the Secondary Prize Raffle so in other words, every 16 hours of classroom /hands-on training puts your name in for another chance for each Prize Category.

:::::: Important Definitions ::::::

Members in Good Standing: An apprentice or journey worker whose dues are currently paid and up to date. Members in good standing who are excluded from the raffle are: Business Manager, Regional Business Representatives/Organizers and staff of the District Council. Training Fund instructors are eligible if they meet the Safe Hour requirement through work under the collective bargaining agreement with a signatory employer, and complete the required courses as a student.

Qualifying Class: Any health, safety or training class offered by or approved of by the Training Fund, completed and passed by you during the Qualifying Period. As stated, you must complete the class to receive credit towards the 16 hour requirement. You cannot duplicate any Health & Safety classes in the Qualifying Period.

Qualifying Period: ***May 1, 2022 to April 30, 2023***

Attending Local Union Meetings: For every Local Union meeting attended during the qualifying period, you will receive one (1) STAR credit hour.

Stipulation: You must attend and complete at least one (1) Health & Safety or Journeyman Upgrading class.

To New Member:

On_____ you made an application with DC#4/Local#677. You agree in part to pay a $100.00 Initiation fee which will be due in 45 days. We have multiple ways for you to pay this fee.

1. You can mail a check to DC#4 Headquarters 585 Aero Dr. Cheektowaga, NY 14225 & attention it to Shannon Albano.

2. You can call (716) 565-0303 and make a payment with Debit/Credit Card. Your contact here again will be Shannon Albano

3. You can also make a payment to the Business Representative of the Local you belong to & will be given a receipt at the time of payment.

Thank you for your timely response to this matter.

Thank you,

Joe Comfort

Regional Business Representative DC#4/Local#677

	PAINTERS DISTRICT COUNCIL #4 HEALTH & WELFARE FUND OPEN ENROLLMENT EFFECTIVE MARCH 1, 2025: BENEFIT SUMMARIES	
	Plan 1	**Plan 2**
IN-NETWORK DEDUCTIBLE CO-INSURANCE OUT OF POCKET MAXIMUM	$500/$1,000 90%/10% $2,500/$5,000	$2,000/$4,000 80%/20% $4,000/$8,000
OUT-OF-NETWORK DEDUCTIBLE CO-INSURANCE OUT-OF-POCKET MAXIMUM	$1,500/$3,000 70%/30% $5,000/$10,000	$3,000/$6,000 60%/40% $6,000/$12,000
PHYSICIAN COPAY SPECIALIST COPAY	$20 $30	$25 $40
HOSPITAL COPAY	$500	20% AFTER DEDUCTIBLE
OUTPATIENT SURGERY COPAY EMERGENCY ROOM URGENT CARE	$75 $150 $50	20% AFTER DEDUCTIBLE $150 $50
PRESCRIPTION DRUG	$5/$30/$50 AT RETAIL (2.5 TIMES AT MAIL)	$5/20%/20% AT RETAIL ($150 MAX/$250 MAX) (2.5 TIMES AT MAIL)
SINGLE RATE TWO-PERSON RATE FAMILY RATE	$806.63 $1,576.27 $2,055.44	$532.10 $1,039.55 $1,422.60

PAP Insurance Splits

	Plan 1	Plan 2
Single	60% HCA – 40% WRA	55% HCA – 45% WRA
2-Person	90% HCA – 10% WRA	85% HCA – 15% WRA
Family	97% HCA – 3% Admin	97% HCA – 3% Admin

No Insurance on File	Waiver on File
80% HCA – 20% WRA	20% HCA – 80% WRA

District Council # 4 Trust Funds Rochester/CNY/Elmira Quick Reference Guide

Contributions being Entered: Contractors have 45 days "after a month end" to send in a remittance report for work performed. When contractors send in monthly reports, it may not reflect the most current work performed, (ie: remittances for work performed for the month of May does not have to be submitted until July 15th).

Effective dates of Contributions: Once the Trust Funds receives a contribution, the member contributions will be based on the following:

HCA/WRA Splits: Basis on how splits are computed:

****A single contribution cannot be split multiple ways regardless of the dollar amount in your HCA/WRA. (This may put your HCA/WRA over the $1,500/$12,500 limit for that single contribution—the next contribution will be split accordingly)**

1. **HCA**-All HCA accounts must be at a minimum of $1,500. Contributions will go 97% into HCA until that amount is met. (3% is admin fee out of the WRA)
2. **WRA**- If WRA reaches $12,500, contributions will revert back to 97% into HCA (3% admin fee out of the WRA)
3. Health insurance type/level of coverage and split:

Single	50/50
2 Person	80/20
Family	97/3
HCA Amt below $1500	97/3
No longer receiving Health Ins	80/20
Waive/ Employer based	20/80
Waive/Non Employer based	20/80

4. Date order of contribution: **A contribution will be allocated as of the Payroll ending date of the contribution.** Therefore whatever the health insurance status is at the payroll ending date of the contribution, will have the split go according to the split table above (in some instances- if contributions are sent in after a more current remittance from a contractor, the date order cannot be followed).

Unemployment PAP Benefits $250: Member must have money in **WRA**, must show proof of unemployment history and complete request form.

Unemployment Waiting Week ($400): Member must have money in **WRA**, must show proof of unemployment history and complete request form.

Medical Reimbursements: This is a reimbursement program, therefore you must pay the bill before submitting for reimbursement. A Claim form along with the patients' name, statement of charges, service provided and date must be submitted with proof of payment, or claim may be denied.

****In order to get reimbursed for out of pocket medical, dental and vision expenses, you must have employer based insurance either through DC#4 or your spouse's employer. If you have your spouse's coverage, a waiver form must be on file showing the dependents who have the employer sponsored coverage. If any dependents are not on employer based coverage, no reimbursements can be made on their behalf.**

Health/Dental Insurance: Members must have the minimum balance of $1,500 in the HCA in order to qualify for coverage. Paperwork will be sent in the mail. Members have 30 days from a qualifying event to enroll or members must wait until the annual Open Enrollment. Call the Trust Funds Office for rates.

Direct Deposit: We offer direct deposit for pap checks (vacations/holidays/medical reimbursements/pap benefits). We need to have the form completed along with a voided check or a statement from the bank with your routing and account number. Direct deposits go in the bank on Thursdays.

** If you owe documentation or need to sign for your check, we cannot release the funds, therefore you will have a paper check that week.

Inactivity Bucket:

If there is no contribution to, or distribution from your Health Care Account or Wage Replacement Account for a period of sixty (60) consecutive months, then any balance in those accounts will be forfeited and added to the Fund's reserves. Further, any balance remaining in your Health Care Account upon your death (if you are not survived by a spouse or eligible dependents), or upon the death of the survivor of your spouse or eligible dependents, will be forfeited and added to the Fund's reserves. Any balance remaining in your Wage Replacement Account will be forfeited upon your death and added to the Fund's reserves.

Vacations:

There is a maximum of six (6) weeks of vacation that can be taken between June 1st and May 31st of the following year. FICA and Medicare taxes are mandatory to be taken as well as personal withholdings for state and federal taxes. Vacations are taken with the status of Apprentice ($850.00 comes out of WRA), Industrial ($850.00 comes out of WRA), or Journeyman ($1,600.00 comes out of WRA). If a member calls in the request, they will need to pick up the check on Thursday or Friday and sign for it. If you owe documentation or need to sign for your check, we cannot release the funds, therefore you will have a paper check that week.

Holidays:

There are nine (9) holidays that can be taken each year. The cut off for taking the prior year's holidays is May 31st. You cannot request a holiday that is more than one week in the future (ie: Christmas Day cannot be requested until **one week prior** to that holiday occurring on the physical Calendar).

HIPAA Forms:

HIPAA forms allow members' spouse, parent or whomever they chose to be able to call/come in to discuss the options below: **PLEASE** complete one as spouses and parents may not understand when we are unable to give them account balances or info on when contributions came in and how much was contributed.

Specific description of information to be used or disclosed: (Please check all that apply)

☐ Health Care Acct Balances ☐ Medical Bills/Receipts ☐ Reimbursement Checks

Specific purpose of the disclosure:

☐ Submission of Medical Claims ☐ Balance, status Inquiries ☐ Allowed to pick up reimbursement checks

Bereavement:

- Up to three (3) days at $300 per day for days missed from the job (you cannot be collecting unemployment)
- You must also have worked the business day before the bereavement days requested for, as well as the day after the last bereavement day requested.
- Funds must be available in the WRA in order to receive this benefit (if the funds are not available at the time of bereavement, this is valid one year from the date of passing).
- Bereavement request from and proof of death (obituary or death certificate) of family member is required.

- This only applies for immediate family members (parent or parent-in law, grand parent, spouse, child or sibling).
- Applicable to Social Security and Medicare employer and employee taxes in addition to federal and state taxes.

Disability/Workers Compensation Benefit:

- Proof of collection of benefits (a copy of the check stub) is mandatory in order to be eligible for such benefits
- These checks are subject to Social Security and Medicare taxes (both employer and employee portions)
- Personal Federal and State taxes are optional to the member
- Funds must be available in your WRA in order to collect these benefits
  ie: for two (2) weeks of disability- a total of $500.00 ($250 each week), you are required to have a balance of $562.75 in your WRA to receive the benefit.

Life Insurance: Members who work 500 hours between May 1st and April 30th of the next year will qualify for our Hartford Life insurance benefit (free of cost). The plan year runs from August 1st to July 31st the following year.

The benefit breakdown is as follows:

- $50,000 coverage for the member
- $5, 000 coverage for the members spouse
- $2,500 coverage for the members eligible dependents ages 6 months to 19 years of age
- $250 coverage for the members eligible dependents ages 14 days to 6 months

Note: A beneficiary designation form is mailed out to all of the members upon qualification that needs to be completed and returned to DC#4 EVERY YEAR. It is ***your responsibility* to make sure the beneficiary form is completed and turned in at a timely manner to ensure you or your beneficiaries will receive these benefits.

Address:

Always keep your address updated with District Council #4. This is very important for mailings, W-2's and checks getting mailed out.

The Address change form is located on our DC4 website or you can obtain the form by calling the District Council #4 Office at 716-565-0303. Address change forms must be notarized and sent back to DC#4.

IUPAT Pension & Annuity Phone #: 1-800-554-2479 Ext. 5533 Any questions on your pension and annuity, you must call this phone number.

SUMMARY OF MATERIAL MODIFICATION
TO THE PLAN OF BENEFITS
OF
PAINTERS DISTRICT COUNCIL NO.4
HEALTH & WELFARE FUND

A. General. This is a summary of material modification regarding the Plan of Benefits, Painters District Council No. 4 Health & Welfare Fund (the "Plan"). This summary of material modification supplements the Summary Plan Description (the "SPD") previously provided to you. You should retain this document with your copy of the SPD.

B. Sponsor Information. The legal name, address and federal employer identification number of the Sponsor are:

Board of Trustees
Painters District Council No. 4 Health & Welfare Fund
585 Aero Drive
Cheektowaga, NY 14225
EIN: 16-6070541

C. Summary Description of Modifications. The Trustees have approved the following changes to your Welfare Plan:

Effective January 1 2024, the Juneteenth holiday has been added as a paid day off under the Plan. Section 3 of Article V of the Plan has been amended to read as follows:

3. Vacation Benefits and Holiday Benefits

You are entitled to up to 6 vacation weeks per Plan Year (June 1 to May 31) and the following 10 holidays per calendar year: New Year's Day, Birthday of Martin Luther King, Jr., Memorial Day, Independence Day, Juneteenth National Independence Day, Labor Day, Veterans Day, Thanksgiving Day, Day After Thanksgiving, Christmas.

The amount of the journeyman benefit shall be $1,416.80 per five consecutive vacation days and $354.20 per holiday. Vacation and holiday benefits for Apprentices and Industrial Members shall be $752.60 per five consecutive vacation days and $354.20 per holiday. Your account will also be reduced by (as applicable) the employer Social Security, Medicare and unemployment taxes, so that the balance required in your account for five vacation days shall be $1,600 for a journeyman and $850 for an Industrial Members. Holidays require a $400 balance.

Claims for holiday and vacation benefits must be made within 60 days of the end of the Plan Year in which they accrue. The Trustees will presume that you are on vacation for any day you are not working for an Employer and for which you do not receive an Unemployment Benefit or Disability Benefit from the Fund.

These benefits are paid from your Wage Replacement Account and may not exceed the balance in your Account.

This notice constitutes your summary of material modifications as required by section 104(b) of ERISA and should be kept with your copy of the Plan's summary plan description and other important plan documents.

District Council #4 Trust Funds
March 2025 Open Enrollment Rates

Please mark your choice below:

Effective Date: _____

	Plan 1	
	Single	$806.63
	Single +1	$1,576.27
	Family	$2,055.44
	Plan 2	
	Single	$532.10
	Single +1	$1,039.55
	Family	$1,422.60

	DENTAL	
	Family	$65.82
	Single	$23.09

Print Name Here: _____

Signature Here: _____

Signature Date: _____

Aetna Dental Rates Starting March 2025

Single Coverage	$23.09
Family Coverage	$65.82

aetna

Painters District Council No. 4 Health & Welfare Trust Fund
Effective Date: 03-01-2021

Dental Benefits Summary

	Active PPO MAX With PPOII and Extend℠ Networks	
	Participating	Non-participating
Annual Deductible*		
Individual	$50	$50
Family	$150	$150
Preventive Services	100%	100%
Basic Services	80%	50%
Major Services	50%	50%
Annual Benefit Maximum	$2,500	$2,500
Office Visit Copay	N/A	N/A
Orthodontic Services**	50%	50%
Orthodontic Deductible	None	None
Orthodontic Lifetime Maximum	$1,000	$1,000

*The deductible applies to: Basic & Major services only
**Orthodontia is covered only for children (appliance must be placed prior to age 20).

Partial List of Services	Active PPO MAX With PPOII and Extend℠ Networks	
	Participating	Non-participating
Preventive		
Oral examinations (a)	100%	100%
Cleanings (a) Adult/Child	100%	100%
Fluoride (a)	100%	100%
Sealants (permanent molars only) (a)	100%	100%
Bitewing Images (a)	100%	100%
Space Maintainers	100%	100%
Basic		
Full mouth series images (a)	80%	50%
Amalgam (silver) fillings	80%	50%
Composite fillings (anterior teeth only)	80%	50%
Uncomplicated extractions	80%	50%
Major		
Inlays	50%	50%
Onlays	50%	50%
Crowns	50%	50%
Stainless steel crowns	50%	50%
Full & partial dentures	50%	50%
Pontics	50%	50%
Scaling and root planing (a)	50%	50%
Gingivectomy (a)*	50%	50%
Root canal therapy		
Anterior teeth / Bicuspid teeth	50%	50%
Molar teeth	50%	50%
Osseous surgery (a)*	50%	50%
Incision and drainage of abscess*	50%	50%
Surgical removal of erupted tooth*	50%	50%
Surgical removal of impacted tooth (soft tissue)*	50%	50%
Surgical removal of impacted tooth (partial bony/ full bony)*	50%	50%
General anesthesia/intravenous sedation*	50%	50%
Denture repairs	50%	50%

*Certain services may be covered under the Medical Plan. Contact Member Services for more details.
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

aetna

New York Employee Enrollment/Change Form

AETNA LIFE INSURANCE COMPANY

151 Farmington Avenue
Hartford, CT 06156

AETNA HEALTH INSURANCE COMPANY OF NEW YORK

151 Farmington Avenue
Hartford, CT 06156

INSTRUCTIONS: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are declining coverage, you must complete section C.** Please use only black ink to complete this form.

Employer group information – To be completed by employer	Aetna member ID number (if available)
Employer/company name – full name of business or organization	
Employer address (street, city, state, ZIP code) – primary location of business or organization	

A. Type of activity – Employee completes sections A – F. ***Please print clearly.***

Effective date / **Date of hire**			
	☐ New hire ☐ Rehire/reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Waiver ☐ Open enrollment ☐ Loss of coverage	☐ Add spouse ☐ Add domestic partner ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination date _____ ☐ Remove spouse ☐ Remove domestic partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____

☐ **COBRA** ☐ **State continuation** for: ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other ____
Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

B. Employee information – ***You must complete this section.***

Social Security number	Last name, first name, middle initial		Job title	
Home address		Apt. number	City, state	ZIP code
Work address			City, state	ZIP code
Home/cell telephone ( ) -	Work telephone ( ) -		Number of hours worked a week	Employee email
Primary language spoken (optional)	Check one: ☐ Full time ☐ Part time	☐ 1099 ☐ Retiree	☐ Seasonal ☐ Temporary	☐ COBRA ☐ Union

C. Declining coverage – ***Check all that apply.***

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:

☐ Employee:	☐ Medical ☐ Vision	☐ Dental	**Reason for declining coverage**	☐ Insurance through another job
☐ Spouse/domestic partner:	☐ Medical ☐ Vision	☐ Dental	☐ Parental group coverage ☐ Spouse/domestic partner group coverage ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ COBRA coverage	☐ TRICARE/Military coverage ☐ Individual coverage – On Exchange ☐ Individual coverage – Off Exchange ☐ Another group plan provided by my employer ☐ Do not want ☐ Other _____
☐ Children:	☐ Medical ☐ Vision	☐ Dental		

I certify I have the right to apply for this coverage. However, I am declining coverage as noted above. By declining this group coverage, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and/or dependents. | ***Date (Month/Day/Year)***

☐ I am declining coverage. **Employee signature:** X

Please PRINT employee name:

D. Plan Options – Check one plan. ***Your selection must be offered by your employer.***

Control number	Suffix	Account	Plan number	Customer Code

1. Medical ☐ Yes ☐ No *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option _____

You may only select a plan offered by your employer.

Aetna Life Insurance Company and/or Aetna Health Insurance Company ***of New York*** *underwrites/administers medical coverage.*

Control number	Suffix	Account	Plan number

2. Dental ☐ Yes ☐ No *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option/name _____ If FOC, choose: ☐ DMO® *or* ☐ PPO/Indemnity

You may only select a dental plan if your employer offers dental coverage.

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

Aetna Life Insurance Company underwrites the Aetna dental plans.

Control number	Suffix	Account	Plan number

3. Aetna Vision℠ Preferred ☐ **Yes** ☐ **No** *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option/name _____

You may only select a vision plan if your employer offers vision coverage.

Aetna Life Insurance Company underwrites Vision insurance plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

E. Individuals covered – ***List individuals for whom you are enrolling or adding, changing or removing coverage. Please complete all information for all individuals. Add more sheets if needed.*** **NOTE FOR MEDICAL COVERAGE:** While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator. Enter domestic partner only if your employer has elected that coverage.

1 ☐ Add ☐ Change ☐ Remove	**Employee name** (Last, first, middle initial)		Sex (M/F/Nonbinary)
Birthdate (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
Dental provider office ID number			Current patient ☐ Yes
Primary office ID number *(if applicable)*	Physician first and last name	Provider ID number *(if applicable)*	Current patient **Yes** ☐

Continued on next page

E. Individuals covered *(Continued)*

2 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner**

Sex (M/F/Nonbinary)

Social Security number

Birthdate (MM/DD/YYYY) / /

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number

Current patient ☐ Yes

Primary office ID number *(if applicable)*

Physician first and last name

Provider ID number *(if applicable)*

Current patient **Yes** ☐

3 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____

Sex (M/F/Nonbinary)

Social Security number

Birthdate (MM/DD/YYYY) / /

Incapacitated ☐ Yes ☐ No

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number

Current patient ☐ Yes

Primary office ID number *(if applicable)*

Physician first and last name

Provider ID number *(if applicable)*

Current patient **Yes** ☐

4 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____

Sex (M/F/Nonbinary)

Social Security number

Birthdate (MM/DD/YYYY) / /

Incapacitated ☐ Yes ☐ No

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number

Current patient ☐ Yes

Primary office ID number *(if applicable)*

Physician first and last name

Provider ID number *(if applicable)*

Current patient **Yes** ☐

5 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____

Sex (M/F/Nonbinary)

Social Security number

Birthdate (MM/DD/YYYY) / /

Incapacitated ☐ Yes ☐ No

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number

Current patient ☐ Yes

Primary office ID number *(if applicable)*

Physician first and last name

Provider ID number *(if applicable)*

Current patient **Yes** ☐

6 ☐ Add ☐ Change ☐ Remove

Name (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____

Sex (M/F/Nonbinary)

Social Security number

Birthdate (MM/DD/YYYY) / /

Incapacitated ☐ Yes ☐ No

Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

Dental provider office ID number

Current patient ☐ Yes

Primary office ID number *(if applicable)*

Physician first and last name

Provider ID number *(if applicable)*

Current patient **Yes** ☐

F. Dependent information

List any dependent in section **E** with a different last name or living at another address.

Name	Address

G. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

Conditions of enrollment

I acknowledge that by enrolling in an Aetna plan, coverage is underwritten or administered by Aetna Life Insurance Company and/or Aetna Health Insurance Company of New York (referred to as "Aetna"). For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, material misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.
2. To support the coverages listed on this enrollment form, Aetna may need information about medical history, services or treatment provided to anyone listed on this form, excluding drug and alcohol records and psychotherapy notes. In accordance with HIPAA regulations, I authorize that the following entities can provide this information to Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers
3. In accordance with HIPAA regulations, I authorize Aetna to use and disclose such minimally necessary information to:
   - Affiliates
   - Providers
   - Other insurers
   - Third party administration
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities

Continued on next page

Conditions of enrollment *(Continued)*

4. I discussed the terms of this authorization with my competent adult dependents. This authorization is valid for 24 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
   - The Group Agreement/Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - I understand and agree that, with the exception of members of the CVS Health family of companies (which includes CVS Pharmacy, CVS Caremark Mail Service Pharmacy, MinuteClinic and CVS Specialty Infusion Services), all other participating providers and vendors are independent contractors and are neither agents nor employees of Aetna or its affiliates. We cannot guarantee the availability of any particular provider outside of our corporate family and the providers in our network may change. We also do not guarantee any results or outcome of a health or dental care service. Notice of any change shall be provided in accordance with applicable state law. I understand that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician
5. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

I represent that all information supplied in this form is true and complete to the best of my knowledge and belief. I agree to the conditions of enrollment and misrepresentation statement on this Employee Enrollment Form. I understand that, if I don't sign this form within 31 days, or Aetna does not receive the request within a reasonable time, my eligibility may be affected.

I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

To receive documents online, please visit your secure member account at aetna.com.

Misrepresentation: 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.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependents. ***Employee signature (required)*** **X**	***Date (Month/Day/Year)***
Spouse / domestic partner signature **X**	***Date (Month/Day/Year)***
Dependent child over the age of majority **X**	***Date (Month/Day/Year)***
Dependent child over the age of majority **X**	***Date (Month/Day/Year)***
Dependent child over the age of majority **X**	***Date (Month/Day/Year)***
Dependent child over the age of majority **X**	***Date (Month/Day/Year)***

Waiver of Group Health Benefits

Painters District Council No. 4 Health and Welfare Fund
585 Aero Dr., Cheektowaga, NY 14225 Ph: 716-565-0234 Fx: 716-565-1494

Please complete the following:

Participant Name: _____ _____ _____
(Last) (First) (MI)

Participant SS# (Last 4 digits): _____ Effective Date____/____/____
(MM/DD/YY)

I am waiving coverage for:

☐ Myself

☐ Spouse – (Name)_____

☐ Dependent (s) – Please list names:_____

Is this an employer sponsored plan? ☐ **Yes** ☐ **No**

I am waiving due to Coverage under:

☐ My own ☐ My spouse's ☐ My parent's plan

Name of carrier: _____

If you are waiving coverage, you must present a copy of your enrollment card.

☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS)
☐ Child Health Plus ☐ Medicaid ☐ Indian Health Service

IMPORTANT: Individual coverage purchased through NY State of Health, Medicare, Medicaid, TRICARE, Child Health Plus or health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations are considered NON- Employer based plans and will not qualify for medical reimbursements.

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Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage.

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (60 days for Medicaid or a State Children's Health Insurance Program). If I do not do so, I will not be able to enroll until the plan's next annual open enrollment period (March 1st).

I understand that in order to request special enrollment due to a qualifying event or obtain more information, I should contact my group administrator.

_____ _____
Signature of Participant Date of Signature