



ORGANIZATION OF STAFF ANALYSTS

WELFARE FUND

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YOUNG ADULT DEPENDENTS

There are two significant pieces of legislation that extend health care coverage for young adults. The NYS Law (Coverage Expansion through Age 29) extends coverage to age 30, and Federal Law (Affordable Care Act Age 26) extends coverage to age 26. Two major differences are: 1) Individual or Family coverage and 2) Married or Unmarried status.

NEW YORK STATE LAW - Coverage Expansion through Age 29

- through Age 29 YOUNG ADULT DEPENDENT coverage
(Individual OSA WF payment)

ELIGIBILITY DATE : IMMEDIATELY

The YAD is between 19 and 30 (except if the Young Adult is already covered by the OSA WF while in school through age 23) is eligible to purchase OSA WF coverage through age 29 if he/she meets the following requirements:

- is a child of OSA active/retired member
- is not married
- is not covered by Medicare, not insured or eligible for other coverage through his/her employer

FEDERAL LAW - Affordable Care Act Age 26

- through age 25 YOUNG ADULT DEPENDENT coverage
(no cost, part of OSA WF Family coverage)

ELIGIBILITY DATE: JANUARY 1, 2011

The YAD who is between 19 and 26 (including those already covered by the OSA WF while in school through age 23) is eligible for the OSA WF coverage through age 25 if he/she meets the following requirements:

- is a child of OSA active/retired member
- is not covered by Medicare, not insured or eligible for other coverage through his/her employer

To enroll in the NYS or Federal YAD you must send a copy of the YAD's birth certificate.

To enroll for current coverage as soon as possible in the NYS YAD you must submit the **NYS YAD enrollment form** along with the payment through **December 31, 2010** for those younger than age 26. For continued coverage for those age 26 to age 30 please submit 3 month payments.

To enroll for **CONTINUED** coverage beginning **January 1, 2011** in the **FEDERAL YAD** for those to age 26 you must submit the **FEDERAL YAD enrollment form**.



**Organization of Staff Analysts (OSA)
NY State Coverage Expansion Law (through Age 29)
Age 29 Young Adult Dependent Coverage**

Eligibility: To be eligible for OSA WF coverage, the Young Adult Dependent does not have to live with an OSA Member, be financially dependent on an OSA Member, or be a student. However, the Young Adult Dependent must meet the following requirements:

- Be unmarried
- Be 29 years or younger
- Not be covered by Medicare, not be insured or eligible for coverage through his/her employer

The OSA member must be active in OSA (active or retired member) in order for his/her Young Adult Dependent to be eligible to purchase OSA WF coverage.

Coverage: OSA Age 29 Young Dependents Coverage is available for the continuation of:

1. Superimposed Major Medical Plan (SMMP), and Dental & Vision Care Programs
2. Dental & Vision Care Programs only, or
3. SMMP only.

If you do not have Basic Health coverage you are not eligible to pay for SMMP, but you are still eligible to pay for Dental & Vision Care.

Election: You must complete and submit the form on the reverse side of this letter on behalf of your Young Adult Dependent within the following time frames:

- 60 days after newly meeting the requirements for dependent child status if coverage previously ended (for example, re-qualifying as a dependent under this new definition).

Cost of Coverage: Checks should be made payable to the Organization of Staff Analysts Welfare Fund and each check should cover a period of three months.

Benefit	Monthly Cost for Calendar
SMMP, Dental & Vision Care Program	\$ 39.08
Dental & Vision Care Program	\$ 32.15
SMMP only	\$ 6.93



Organization of Staff Analysts

220 E 23rd St, Suite 707, New York NY 10010

**NY State Coverage Expansion Law - IMMEDIATE ENROLLMENT
AGE 29 YOUNG ADULT DEPENDENT COVERAGE ENROLLMENT FORM**

Eligibility requirements - The Young Adult child must be: under age 30; and be unmarried; and be a child of the OSA member; and not be covered by, or eligible for, employer-sponsored insurance, a self-insured employment plan, or Medicare.

DIRECTIONS-Provide the following information in full and mail the signed form to OSA, 220 E 23rd St, Suite 707, NYC, NY 10010, Attn. Young Adult Option

MEMBER'S INFORMATION - ACTIVE **RETIREE** (YOU MUST CHECK ONE)

Last name: _____ First name: _____ Social Security Number: _____ Home Telephone #: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____ Name of City Agency employed by/retired from: _____

YOUNG ADULT INFORMATION

Last Name: _____ First name: _____ Social Security Number: _____ Home Telephone #: _____

Address: _____ Apt. #: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____ Relation to Member: _____

I, as the Young Adult, certify that I meet the eligibility requirements as stated above and that the above information is complete and correct and agreed that I will be fully responsible for payment of the premium due with respect to the dependant coverage being requested as of the Effective date.

Signature of Young Adult Applicant _____ Print Name _____ Effective Date _____

I understand that any person who knowingly and with intent to defraud any insurance company or other persons who files an application for insurance or statement of claims containing any materially false information, or conceals for 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 Member _____ Print name _____ Date _____

Benefits requested: SMMP, Dental and Vision Dental and Vision SMMP

Initial payment for three months is enclosed for \$ _____ for the period / / through / / . Follow-up payments should be in three-months payments for those Young Adults between 26 and 30.

NOTE: If OSA does not receive a copy of your Health Card, you will not be eligible to purchase OSA Superimposed Medical Benefits.



Organization of Staff Analysts
220 E 23rd St, Suite 707, New York, NY 10010
FEDERAL Law - Affordable Care Act Age 26
AGE 26 YOUNG ADULT DEPENDENT COVERAGE ENROLLMENT FORM
Start Date January 1, 2011

INSTRUCTIONS: 1 - Complete a separate application for Young Adult Coverage for each dependent child between the ages of 19 and 26 for whom you are requesting OSA WF coverage.
2 - Send a copy of your child's birth certificate along with this completed form, signed by the member.

PLEASE NOTE: In order to be eligible for the Age 26 Coverage, your dependent child must not be insured, or eligible for comprehensive health insurance through his/her employment.

Must Be Completed By Member:

Member's Name: _____ SS# _____ - _____ - _____

Address: _____ Apt #: _____

City, State, Zip: _____

Work phone: _____ Home phone: _____ Cell: _____

Dependent Child's name: _____ Dependent Child's Date of Birth: _____

Relationship to Member: _____ Dependent Child's SS#: _____ - _____ - _____

Address (if different from Member's) _____ Apt #: _____

City, State, Zip: _____

Is your Dependent child currently employed: YES
 NO

If YES, please provide the following information regarding your dependent child.

Employer's Name: _____

Employer's Address: _____

City, State, Zip: _____

Employer's Telephone #: _____

ATTESTATION: Health coverage is not available from my dependent child's employer.

Signature of Member: _____ Date: _____