ORGANIZATION OF STAFF ANALYSTS
WELFARE FUND

220 EAST 23rd STREET - SUITE 707
NEW YORK, N.Y. 10010
WEB: WWW.OSAUNION.ORG

TEL.: (212) 686-1229
FAX: (212) 686-1231

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.

FEDERAL LAW - Affordable Care Act Age 26
- through age 25 YOUNG ADULT DEPENDENT coverage
(no cost, part of OSA WF Family coverage)

The YAD who is between 19 and 26 is eligible for the OSA WF coverage through age 25 if he/she is a child of OSA active or retired member. NO ADDITIONAL ACTION REQUIRED.

NEW YORK STATE LAW - Coverage Expansion through Age 29
- through **Age 29** YOUNG ADULT DEPENDENT coverage
(Individual OSA WF payment)

The YAD between 26 and 30 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

IF YOU WISH TO ENROLL YOUR ELIGIBLE CHILD, PLEASE SEE THE FOLLOWING INSTRUCTIONS.

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 between ages 26 - 30
- 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 of date of eligibility 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 Effective January 1, 2013**
SMMP, Dental & Vision Care Program	$ 30.68
Dental & Vision Care Program	$ 23.53
SMMP only	$ 7.15

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_____ Eligibility 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.