CSEA Employee Benefit Fund Enrollment Form

☐	Dental
☐	Vision - family
☐	Vision - single

PO Box 516
Latham, NY 12110
800-323-2732
www.cseaebf.com

Employee Information (Please Print)

Social Security # _____ Date of Birth _____ /_____ /_____

Name (First, Middle Initial, Last) _____ Please (✓) one: ❑ M ❑ F

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Employee's Daytime Phone # _____ Email _____

Name of Employer _____

Spouse/Domestic Partner Information

Please (✓) one: ❑ Spouse ❑ Domestic Partner* Date of Marriage _____ /_____ /_____ Please (✓) one: ❑ M ❑ F

Name (First, Middle Initial, Last) _____

Date of Birth _____ /_____ /_____ Social Security # _____

Dependent Children Information (For relationship, please indicate: Son, Daughter, Step-child or other)

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

If you are enrolling for a CSEA EBF Dental Plan, please answer the following: Do you and/or your dependents have other dental coverage available? ❑ Yes ❑ No

If yes, please indicate: Name of other plan: _____ Effective Date: _____ /_____ /_____

*Important Information concerning dependent coverage

- *Not all employers allow domestic partner coverage.* For New York State Employees; before enrollment of a domestic partner can be completed, the CSEA EBF must receive eligibility confirmation from The NYS Department of Civil Service. For Local Government employees, the confirmation must come from your employer. For purposes of IRS reporting, it is necessary that you provide your domestic partner's social security number on this form.
- When enrolling dependent children, it may be necessary for the CSEA EBF to require and/or request additional infomation which may include full-time student verification for children ages 19 and over, verification of eligibility by "Proof of Dependency" form, copy of Birth Certificate and/or "Certification of Disability" form.
- In certain instances, a copy of a Marriage Certificate may be requested for proof of eligibility.
- An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are EBF members, coverage may not be claimed under both plans.

For a detailed outline of eligibility rules, please refer to your Summary Plan Description or visit our website at www.cseaebf.com

I certify that the above information is correct:

Member's Signature _____ Date _____