

# CSEA Employee Benefit Fund Enrollment Form



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

## Employee Information (Please Print)

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name (First, Middle Initial, Last) \_\_\_\_\_ Please (✓) one:  M  F

Mailing 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 information 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.cseabf.com](http://www.cseabf.com)

I certify that the above information is correct:

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_