CSEA Employee Benefit Fund
Proof of Dependency Form

A. Employee Information (PLEASE PRINT)

Member's Name _____ EBF ID# _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Email _____

B. Dependent Information

Please provide a copy of the dependent's BIRTH CERTIFICATE with this form.

Dependent's Name _____ Dependent's DOB _____

Natural Parent's Name _____ Natural Parent's DOB _____

Dependent's relationship to you: ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter

☐ Grandchild * ☐ Other *

** Please provide a copy of the court order awarding you legal guardianship/custody over this child.*

C. Where does the dependent reside?

Does this dependent reside at your home? ☐ Yes ☐ No If yes, give the date when such residence began: _____

D. Other dental coverage?

Does this dependent have other dental coverage? ☐ Yes ☐ No

If yes, please indicate the name of the other plan _____ Effective Date _____

E. Signature and Date

Member's Signature _____ Date _____

MAIL COMPLETED FORM TO

CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516