# CSEA Employee Benefit Fund

## Proof of Dependency Form

### A. Employee Information (PLEASE PRINT)

<table>
<thead>
<tr>
<th>Member's Name</th>
<th>EBF ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address</td>
<td>Apt #</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Daytime Phone #</td>
<td>Email</td>
</tr>
</tbody>
</table>

### B. Dependent Information

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

<table>
<thead>
<tr>
<th>Dependent's Name</th>
<th>Dependent's DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural Parent's Name</td>
<td>Natural Parent's DOB</td>
</tr>
</tbody>
</table>

Dependent's relationship to you:  
- [ ] Son  
- [ ] Daughter  
- [ ] Stepson  
- [ ] Stepdaughter  
- [ ] Grandchild  
- [ ] Other

Does this dependent reside at your home?  
- [ ] Yes  
- [ ] No

If yes, give the date when such residence began:

How long do you anticipate such residence will continue:

Give a brief explanation why this dependent lives with you and is dependent upon your support:

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* If the dependent is a *grandchild*, please return this form with a **copy of the court order awarding you legal guardianship over this child**. If the grandchild’s natural parent is over the age of 19 and a full-time student, a student proof letter must be submitted. Legal guardianship is not required.

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

### C. Other dental coverage?

Does this dependent have other dental coverage?  
- [ ] Yes  
- [ ] No

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

### D. Signature and Date

| Member's Signature | Date |

MAIL COMPLETED FORM TO

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

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CSEA Employee Benefit Fund  
1-800-323-2732  
www.cseaebf.com