Member Plus

DENTAL & VISION ENROLLMENT FORM

Please indicate the plan(s) and coverage you are electing:

DENTAL	VISION
Please (✓) one:	Please (✓) one:
☐ Individual	☐ Individual
☐ Two Person	☐ Two Person
☐ Family	☐ Family

CSEA NEW YORK Employee Benefit Fund
PO Box 516
Latham NY 12110
www.cseaebf.com
800-323-2732

Employee Information (PLEASE PRINT)

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

Name (First, Middle Initial, Last)_____ Male ❑ Female ❑ Other ❑

Street Address_____ Apt.#_____

City_____ State_____ Zip Code_____

Daytime Phone #_____ Name of Employer_____

Department_____ Job Title_____

Spouse/Domestic Partner Information

(Please ✓One) Spouse ☐ Domestic Partner* ☐ Date of Marriage _____/_____/_____ Male ❑ Female ❑ Other ❑

Name (First, Middle Initial, Last)_____

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

Dependent Children Information (For relationship please indicate: Son, Daughter, Child, Step-Child or Other*)

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

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

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

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

If you are enrolling in the EBF Member Plus Dental Plan please answer the following

Do you and/or your dependents have other dental coverage available? Please (✓) one: Yes ☐ No ☐

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

*Important Information concerning dependent coverage

- Not all employers allow domestic partner coverage. Before enrollment of a domestic partner can be completed, the CSEA EBF must receive eligibility confirmation 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 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.

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 and I agree to maintain enrollment for myself and any dependents enrolled for a period of at least 12 months, unless there is a qualifying event. I understand that if I voluntarily terminate coverage at any point I may not be able to re-enroll again at a later date. *Detailed information can be found here:* **www.cseaebf.com/faq**

Employee Signature _____ Date _____