



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

DENTAL

Please  one

- Individual, Two Person, Family

VISION

Please  one

- Individual, Two Person, Family



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

ENROLLMENT FORM

Employee Information

Social Security #, Date of Birth, Name, Street Address, City, State, Zip Code, Daytime Phone #, Name of Employer

Spouse/Domestic Partner Information

Please (X) one: Spouse, Domestic Partner\*, Date of Marriage, Date of Birth, Social Security #, Name

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

First Name, Last Name, Date of Birth, Relationship (M/F) for three children

If you are enrolling in the Solstice 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... When enrolling dependent children... In certain instances, a copy of a Marriage Certificate may be requested...

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

Employee Signature, Date