

# CSEA Employee Benefit Fund Enrollment Form

Blue Collar  
Vision Insurance



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

## Employee Information

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name (First, Middle Initial, Last) \_\_\_\_\_  M  F ()  
Street Address \_\_\_\_\_ Apt.# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Employee's Daytime Phone # \_\_\_\_\_ E-mail \_\_\_\_\_

## Spouse/Domestic Partner Information

Please () one: \_\_\_\_ Spouse \_\_\_\_ Domestic Partner\* Date of Marriage \_\_\_\_/\_\_\_\_/\_\_\_\_  M  F ()  
Name (First, Middle Initial, Last) \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_

## Dependent Children\* (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 \_\_\_\_\_  
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. 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.

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:**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

