CSEA
AFSCME Local 1000, AFL-CIO
EMPLOYEE BENEFIT FUND

RESET PRINT

CSEA-EBF ENROLLMENT FORM
See reverse for instructions

1 EMPLOYEE: 2 EMPLOYEE SOCIAL SECURITY #

LAST NAME | FIRST NAME | MIDDLE INITIAL

3 HOME ADDRESS | CITY/TOWN | STATE | ZIP

4 NEW ADDRESS? YES NO

5 MALE ☐ FEMALE ☐ 6 DATE OF BIRTH MO DAY YR

7 DATE OF MARRIAGE/PARTNERSHIP MO DAY YR

8 SPOUSE'S/PARTNER'S SS#

9 SPOUSE'S/PARTNER'S EMPLOYER

10 ADDRESS OF SPOUSE'S/PARTNER'S EMPLOYER:

STREET | CITY/TOWN | STATE | ZIP

11 IF ENROLLMENT IS FOR DENTAL, IS ANY OTHER COVERAGE AVAILABLE? YES ☐ NO ☐

12 IF ENROLLMENT IS FOR PRESCRIPTION DRUG, IS ANY OTHER COVERAGE AVAILABLE? YES ☐ NO ☐

13 IF QUESTION #11 WAS CHECKED YES, INDICATE NAME OF OTHER PLAN:

14 IF QUESTION #12 WAS CHECKED YES, INDICATE NAME OF OTHER PLAN:

15 LIST BELOW SPOUSE/DOMESTIC PARTNER AND ELIGIBLE DEPENDENTS

		CHECK (X) RELATIONSHIP						DATE OF BIRTH			SEX	
LAST NAME	FIRST NAME	Wife	Husband	Domestic Partner	Son	Daughter	Other	MO	DAY	YR	M	F

16 I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT: EMPLOYEE'S SIGNATURE DATE: