Solstice

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 EMPLOYEE BENEFIT FUND
PO Box 516
Latham NY 12110
www.cseaebf.com
800-323-2732

Employee Information

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

Name (First, Middle Initial, Last) _____ ☐ Male ☐ Female

Street Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Name of Employer _____

Spouse/Domestic Partner Information

Please (**X**) one: ____Spouse _____Domestic Partner* Date of Marriage ____ /____ / _____ ☐ Male ☐ Female

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

Name (First, Middle Initial, Last) _____

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

First Name_____Last Name_____Date of Birth ____ /____ / _____ ☐ M ☐ F Relationship_____

First Name_____Last Name_____Date of Birth ____ /____ / _____ ☐ M ☐ F Relationship_____

First Name_____Last Name_____Date of Birth ____ /____ / _____ ☐ M ☐ F Relationship_____

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. 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 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.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.

Employee Signature _____ Date _____