



ENROLLMENT FORM

Please indicate the coverage you are electing:

DENTAL

Please ☒ one

- ☐ Individual
☐ Two Person
☐ Family



PO Box 516
Latham NY 12110
www.cseabf.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.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 _____

