



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

<b>DENTAL</b>	<b>VISION</b>
<i>Please <input checked="" type="checkbox"/> one</i>	<i>Please <input checked="" type="checkbox"/> one</i>
<input type="checkbox"/> Individual	<input type="checkbox"/> Individual
<input type="checkbox"/> Two Person	<input type="checkbox"/> Two Person
<input type="checkbox"/> Family	<input type="checkbox"/> Family



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800-323-2732

## ENROLLMENT FORM

### 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](http://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 \_\_\_\_\_