OFFICE USE ONLY

EFFECTIVE DATE _____

ID # _____

CSA RETIREE WELFARE FUND

ENROLLMENT CARD

OFFICE USE ONLY

MAIN MENU_____

DENTAL _____

SOC. SEC. NO. _____ **PENSION # _____** **DATE OF BIRTH: Month _____ Day ____ Year_____**

(Print) Last Name _____ **First Name_____** **Middle Initial _____**

Home Address _____ **City _____** **State _____ Zip _____**

Home Tel.# (_____)_____ **Email Address _____** **Last Position : _____**

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Male☐ Female☐ **Single☐ Married☐ Domestic Partner☐ Widowed ☐ Divorced☐**

Date of Marriage or Dom. Ptnr. Certification	Month	Day	Year

My City Basic Plan is (Check one) HIP☐ GHI-CBP☐ Other☐ _____

Spouse/Domestic Partner's Soc. Sec. # _____ **Is Spouse/Dom. Ptnr. employed? Yes☐ No☐** **Retired? Yes☐ No☐**

Name of Spouse/domestic partner's Employer or Retired from: _____

Is Group Insurance Available from Spouse/Dom. Ptnr's Employer/retirement? Yes☐ No☐ **If Yes, Check Coverage Provided : Dental☐ Hospital☐ Medical☐ Optical☐ Drugs☐**

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List Below all Dependents eligible for coverage:	Wife	Husband	Dom. Ptnr.	Son	Daughter	Date of Birth	Social SecurityNumber
1.							
2.							
3.							
4.							
5.							

Signature of Member _____ **Date Card is Signed _____**