OFFICE USE ONLY

CENTER #: ______________________________

EFFECTIVE DATE __________________________

ID # ________________________________

DCC/CSA WELFARE FUND ENROLLMENT CARD

OFFICE USE ONLY

MAIN MENU______________________________

DENTAL _________________________________

CENTER FISCAL # ___________________________ **SPONSOR NAME:** ____________________________

SOC. SEC. # _____________-_______-_______________ **BIRTHDATE:** ____________________ **HEALTH PLAN COVERAGE:** Individual ☐ H/W ☐ P/C ☐ Family ☐

****

Last Name ____ First Name ____ Middle initial _____

Home Address _____________________________________ City _____________________________ State _____________ Zip Code ______________________

Home Tel # ____ Cell Tel. # ____

Email Address: ____ Job Title: _____________________-_______________________

Center Name ____ Center Address ____________________________________ Telehone # ____________________

****

Male ☐ Female ☐ Single ☐ Married ☐ Dom.Ptnr. ☐ Widowed ☐ Divorced ☐

Is Spouse/D.P. employed? Yes ☐ No ☐ Spouse's Soc. Sec. #______________________

Marriage date or Domestic Ptnr. Certificate.	Month	Day	Year

Name of Spouse's Employer: ____

Is Group insurance available from spouse's Employer: Yes ☐ No ☐

If Yes, check coverage provided by their employer: Dental ☐ Medical ☐ Hospital ☐ Optical ☐ Drugs ☐

****

List below Husband, Wife and dependents eligible for coverage: Wife Husband Dom. Ptnr. Son Daughter Date of Birth Social Security Number

1.

2.

3.

4.

5.

BENEFICIARY (If more than one beneficiary, indicate "and" or "or" after address).

Relationship	Name	Address	and/or
My ______________________	______________________	____	_____
My ______________________	______________________	____	_____

SIGNATURE X ____ **Date Signed X** ______________________________