OFFICE USE ONLY

EFFECTIVE DATE _____

ID # _____

CSA WELFARE FUND ENROLLMENT CARD

OFFICE USE ONLY

MAIN MENU _____

DENTAL _____

RX _____

AGE 26 PLAN

SOC. SECURITY # _____ FILE # _____ DATE OF BIRTH: ____/____/____

Full Name: _____
Last *First* *M.I.*

Address: _____

City, State. Zip code _____ *Apartment/Unit #*

Telephone: ( ) _____ Email: _____

Current City Health Plan GHI ☐ HIP ☐ OTHER ☐: IIII ☐ Male ☐ Female ☐ Single ☐ Married ☐ D.Ptnr. ☐ Divorced ☐ Widowed

Position Title: _____ School Assigned: _____

School Address: _____ School Tel. #: ( ) _____

Marriage date or Domestic Ptnr. Certificate.	Month	Day	Year

Spouse/Dom. Ptnr's Soc. Sec. # _____ Is Spouse/Dom. Ptnr. employed? _____ Yes _____ No

Spouse/domestic partner's Employer _____

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

List Below all 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 _____ Date Signed _____