OFFICE USE ONLY

EFFECTIVE DATE ______________________________

ID # ______________________________

SURVIVOR ENROLLMENT CARD

CSA WELFARE FUND

ACTIVE RETIREE

OFFICE USE ONLY

MAIN MENU ____________________________

DENTAL ____________________________

SOC. SEC. NO. ___________________________________ DATE OF BIRTH: Month _____ Day ____ Year_____

(Print) Last Name ____ First Name________________________________ Middle Initial __________

Home Address ____ City ____________________________________ State _____ Zip ______________

Home Tel. No (_____)________________________ Email Address ____

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Male☐ Female☐ Employed ☐ Retired ☐

Name of Employer ____ Coverage Provided by Employer : Medical☐ Hospital☐ RX☐

My Medical Plan is (Check one) HIP ☐ GHI-CBP ☐ Other _________________________________

****

DECEASED MEMBER'S NAME ____ Social Security # _____________________________________

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List Below any unmarried children under 26 years or handicapped Dependents eligible for coverage:	Son	Daughter	Date of Birth	Social SecurityNumber
1.				
2.				
3.				

Signature of Member ____ Date Card is Signed ______________________________________