

Enrollment Form

Group Name: Yonkers CLSA Welfare Fund

		Me	ember In	formation			
All field	ds are required. Please	e Print.					
Last Name Street Address Date of Hire		First Name City Effective Date		Social Sec	urity No.	Date of Birth	
				State Phone Number		Zip	
	tal Status:	e 🗆 Ma			orced	□ Legal Separation	
			Cover	age			
	Please com	plete the below for a	all to be co	vered under l	Plan, including you	rself.	
	Last Name	First Name	Social S	Security No.	Sex (M/F)	DOB MM/DD/YYYY	
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Additional Documentation Checklist If applicable, please send in copies of the following documentation along with this completed form:										
If applicable, ple	ease send in <u>copies</u> o	f the followi	ng documentation alon	g with this com	npleted form:					
□ Social Security Card(s)□ Birth Certificate(s)		□ D	Death CertificatesMarriage Certificate or QDRO/Divorce Documents		English translation for all foreign documents submitted					
			Additional Coverage	e						
Do you, or any of your dependents covered, also have coverage through another dental or vision plan? □ YES (Please check one)										
If YES, please complete the information in the chart below for <u>each covered individual</u> who is enrolled in the plan: Other Coverage Last Name First Name Date of Birth Relationship to Employee										
Other Coverage	Last IValli		i ii st ivallie	Date Of Bil	ti Nelationship to Employee					
			Signature							
Member Signa	Date									
	Please Return Your	•	Form to:	OR OR	Email Your Complete Form to:					
c	onkers CLSA Welfa O Daniel H. Cook A O40 6th Avenue, 24	ssociates, I	Inc.	Elig	gibility.dept@dhcook.com					

Questions? You can call our Customer Service Department at (914) 250 – 0700.

New York, NY 10018