DANIEL H. COOK
ASSOCIATES INC

Enrollment Form

Group Name: HARRISON SCHOOL UNIT BENEFIT FUND CSEA
NY LOCAL 860 UNIT 9180

Member Information

All fields are required. Please Print.

Last Name	**First Name**	**Social Security No.**	**Date of Birth**
Street Address	**City**	**State**	**Zip**
Date of Hire	**Effective Date**	**Phone Number**	**Email**

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Please Check One: ☐ New Hire ☐ Open Enrollment ☐ Life Status Change

School Building: _____ **Group:** ☐ Civil Service ☐ Managerial Confidential

Coverage

Please complete the below for all to be covered under the Benefit Plan: If you wish to cover any eligible dependent, you must elect coverage for all your eligible dependents.

	Last Name	First Name	Social Security No.	Sex (M/F)	DOB MM/DD/YYYY
Spouse					
Child					
Child					
Child					
Child					

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Additional Documentation Checklist

If applicable, please send in copies of the following documentation along with this completed form:

- ☐ Social Security Card(s)
- ☐ Birth Certificate(s)
- ☐ Marriage Certificate or QDRO/Divorce Documents
- ☐ Death Certificates
- ☐ Proof of Disability for all disabled dependents
- ☐ English translation for all foreign documents submitted

Selection of Benefits

The CSEA School Unit Benefits Trust Fund is the Provider of the following Benefits. Please complete the following information as well as select whether you wish to have Dental Coverage. All payments will be deducted through payroll.

Benefit	Selection	Details & Annual Cost
Dental	☐	**Family** $200.00 _____ **Single** $100.00 _____
Vision	***Included***	**No Cost – Through Davis Vision**
Group Life Insurance	***Included***	**No Cost – Through UNUM**
Pre-Paid Legal Plan	***Included***	**No Cost – Through Harold, Salant, Strassfield & Rotbard, LLP**

Additional Coverage

Do you, or any of your dependents covered, also have coverage through another dental or vision plan? (Please check one)

- ☐ YES
- ☐ NO

If YES, please complete the information in the chart below for each covered individual who is enrolled in the plan:

Other Coverage	Last Name	First Name	Date of Birth	Relationship to Employee

Signature

Member Signature **Date**

I certify that the information provided in this enrollment form is true to the best of my knowledge.

Employee Authorization for Payroll Deduction for Dental Coverage as elected above:

Signature **Date**

BELOW TO BE COMPLETED BY A TRUST FUND REPRESENTATIVE

Date of Employment: _____ Effective Date of Enrollment: _____

Enrollment Type: ___ New ___ Change ___ Terminate Eff _____ Retire ____