CSEA Employee Benefit Fund
Proof of Dependency Form

Please complete this form to add eligible dependents to your EBF benefit. (PLEASE PRINT)

Member's Name _____ EBF ID# _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Email _____

Dependent's Name _____ Dependent's DOB _____

Natural Parent's Name _____ Natural Parent's DOB _____

Dependent's relationship to you: ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Grandchild * ☐ Other **

If other, please explain: _____

Does this dependent reside at your home? ☐ Yes ☐ No

If yes, give the date when such residence began _____

How long do you anticipate such residence will continue? _____

Give a brief explanation why this dependent lives with you and is dependent upon your support:

_____

_____

_____

Does this dependent have other dental coverage? ☐ Yes ☐ No

If yes, please indicate the name of the other plan _____ Effective Date _____

** If the dependent is a **grandchild**, please return this form with a **copy of the court order awarding you legal guardianship over this child.** If the grandchild's natural parent is over the age of 19 and a full-time student, a student proof letter must be submitted. Legal guardianship is not required.*

*** Please provide a copy of the court order awarding you legal guardianship/custody over this child.*

Signature _____ Date _____

This form must be fully completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached. **Incomplete forms will be returned.**

MAIL COMPLETED FORM TO

CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516