Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

CIVIL SERVICE BAR ASSOCIATION SECURITY BENEFITS FUND ENROLLMENT FORM

333 WESTCHESTER AVENUE – WHITE PLAINS, NY 10604
Tel.: (866) 627-4617 Fax: (914) 367-5793

PLEASE PRINT

EMPLOYEE NAME (LAST, FIRST, MI) | EMPLOYEE SOCIAL SECURITY # | SEX | EMPLOYEE DOB

EMPLOYER NAME | EMPLOYMENT DATE | SALARY | OFFICE TELEPHONE NUMBER

HOME ADDRESS

CITY | STATE | ZIP CODE | HOME TELEPHONE NUMBER

EMAIL ADDRESS

SPOUSE OR REGISTERED DOMESTIC PARTNER NAME (LAST, FIRST, MI) | SPOUSE OR DOMESTIC PARTNER SOCIAL SECURITY # | SEX | SPOUSE OR DOMESTIC PARTNER BIRTHDATE

Please provide copy of marriage certificate

ARE YOU ENROLLING A REGISTERED DOMESTIC PARTNER? ☐YES ☐NO
IF YES, PLEASE ATTACH THE CERTIFICATE OF DOMESTIC PARTNERSHIP FROM THE CITY OF NEW YORK.

IS YOUR SPOUSE/REGISTERED DOMESTIC PARTNER EMPLOYED? ☐YES ☐NO

IF YES, PLEASE SUPPLY THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR SPOUSE'S/REGISTERED DOMESTIC PARTNER'S EMPLOYER:

_____

DOES YOUR SPOUSE/REGISTERED DOMESTIC PARTNER OR ANY OTHER DEPENDENTS HAVE OTHER INSURANCE COVERAGE? ☐YES ☐NO

IF YES, PLEASE SPECIFY THE NAME, ADDRESS AND TELEPHONE NUMBER OF ALL OTHER INSURANCE COVERAGE: _____

MEDICAL _____

DRUG _____

DENTAL _____

OPTICAL _____

NAME OF DEPENDENT CHILDREN (LAST, FIRST, MI)	RELATIONSHIP	SEX	BIRTHDATE	Social Security No.	CHILDREN MENTALLY RETARDED OR PHYSICALLY HANDICAPPED	DATE OF DISABILITY MONTH DAY YEAR

CONTINUED ON BACK >

PLEASE PRINT

NAME OF DEPENDENT CHILDREN (LAST, FIRST, MI)	RELATIONSHIP	SEX	BIRTHDATE	FULL-TIME STUDENT	CHILDREN MENTALLY RETARDED OR PHYSICALLY HANDICAPPED	DATE OF DISABILITY MONTH DAY YEAR
				☐YES ☐NO		
				☐YES ☐NO		
				☐YES ☐NO		

Please provide copy of Birth Certificate for each child under coverage

BENEFICIARY INFORMATION

PRIMARY BENEFICIARIES

NAME OF PRIMARY BENEFICIARY (LAST, FIRST, MI) | RELATIONSHIP | DATE OF BIRTH

Please Indicate Percentage of Benefit:

HOME ADDRESS

CITY | STATE | ZIP CODE | HOME TELEPHONE NUMBER

NAME OF PRIMARY BENEFICIARY (LAST, FIRST, MI) | RELATIONSHIP | DATE OF BIRTH

Please Indicate Percentage of Benefit:

HOME ADDRESS

CITY | STATE | ZIP CODE | HOME TELEPHONE NUMBER

CONTINGENT BENEFICIARIES

NAME OF CONTINGENT BENEFICIARY (LAST, FIRST, MI) | RELATIONSHIP | DATE OF BIRTH

Please Indicate Percentage of Benefit:

HOME ADDRESS

CITY | STATE | ZIP CODE | HOME TELEPHONE NUMBER

NAME OF CONTINGENT BENEFICIARY (LAST, FIRST, MI) | RELATIONSHIP | DATE OF BIRTH

Please Indicate Percentage of Benefit:

HOME ADDRESS

CITY | STATE | ZIP CODE | HOME TELEPHONE NUMBER

X _____

EMPLOYEE SIGNATURE | DATE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.