UNION TRANSFERRED FROM: _____

DATE OF TRANSFER: _____

OFFICE USE ONLY

DATE ELIGIBLE: _____

T: _____ D: _____

☐ H + W ☐ FAMILY ☐ IND

ENROLLMENT CARD

SSEU LOCAL 371 Benefit Funds

P.O. Box 672 • Cooper Station • N.Y.C. 10276-0672 • (212) 777-9000

THIS CARD MUST BE ON FILE AT THE FUND OFFICE BEFORE CLAIMS CAN BE PROCESSED.
PLEASE PRINT or TYPE ALL INFORMATION.

A MEMBER INFORMATION

LAST NAME	FIRST NAME	INIT	DATE OF BIRTH (MONTH / DAY / YEAR)	SOCIAL SECURITY NO.

SEX	CITY DEPARTMENT FOR WHICH YOU WORK	WORK PHONE	HOME PHONE
☐ F ☐ M		( )	( )

PAYROLL TITLE	DATE EMPLOYED (MONTH / DAY / YEAR)	MEMBER'S E-MAIL ADDRESS

HOME ADDRESS: No. Street Apt. No. City State Zip Code

MARITAL STATUS	☐ SINGLE	☐ MARRIED/DOMESTIC PARTNER Date:	☐ SEPARATED Date:	☐ DIVORCED Date:	☐ WIDOWED Date:

EDUCATIONAL LEVEL: *(Circle)*

College: 1Yr 2Yr 3Yr 4Yr BA BS Other _____ **High School Grad or Equiv:** ☐ Yes ☐ No

If no high school diploma, circle highest year completed: 4 5 6 7 8 9 10 11

B SPOUSE/PARTNER INFORMATION

SEX	FIRST NAME	LAST NAME (IF DIFFERENT FROM MEMBER'S)	SOCIAL SECURITY NO.	DATE OF BIRTH (MONTH / DAY / YEAR)
☐ F ☐ M				

EMPLOYER	WORK ADDRESS	WORK PHONE	DATE EMPLOYED (MONTH / DAY / YEAR)
		( )	

SPOUSE'S/ PARTNER UNION	NAME OF SPOUSE'S/PARTNER'S UNION	ADDRESS OF SPOUSE'S/PARTNER'S UNION

Does Your Spouse Have Dental Coverage? ☐ Yes ☐ No

If Yes, Name of Insurance Company or Union Plan: _____

LIST BELOW THE NAMES OF UNMARRIED DEPENDANT CHILDREN UNDER AGE 19, or UNDER AGE 23, IF A FULL-TIME STUDENT:

	FIRST NAME	LAST NAME (If Different From Member's)	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATIONSHIP SON	RELATIONSHIP DAUGHTER	OFFICE USE
C							
D							
E							
F							
G							
H							

BENEFICIARY DESIGNATION

I authorize any doctor, other practitioner, hospital or other institution to give the Social Service Employees Union Local 371 Benefit Funds any information required with reference to treatments, examinations, advice or confinement in a hospital or other institution of myself or of my minor children. In addition, I hereby name as my beneficiary(ies) to receive Life Insurance Benefits which may be payable through the Social Service Employees Union Local 371 Benefit Funds, in the event of my death.

NAME			RELATIONSHIP		
ADDRESS: No. Street	APT. NO.	CITY	STATE	ZIP CODE	
NAME			RELATIONSHIP		
ADDRESS: No. Street	APT. NO.	CITY	STATE	ZIP CODE	
NAME			RELATIONSHIP		
ADDRESS: No. Street	APT. NO.	CITY	STATE	ZIP CODE	

MEMBER'S SIGNATURE: _____ DATE: _____