

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			SOCIAL SECURITY NO.	
					MONTH	DAY	YEAR		
SEX	<input type="checkbox"/> F <input type="checkbox"/> M	CITY DEPARTMENT FOR WHICH YOU WORK				WORK PHONE		HOME PHONE	
				()		()			
PAYROLL TITLE			DATE EMPLOYED		MEMBER'S E-MAIL ADDRESS				
			MONTH / DAY / YEAR						
HOME ADDRESS: No.		Street		Apt. No.	City		State	Zip Code	
MARITAL STATUS	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED/DOMESTIC PARTNER		<input type="checkbox"/> SEPARATED		<input type="checkbox"/> DIVORCED		<input type="checkbox"/> WIDOWED	
		Date: _____		Date: _____		Date: _____		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	<input type="checkbox"/> F <input type="checkbox"/> M	FIRST NAME	LAST NAME (IF DIFFERENT FROM MEMBER'S)		SOCIAL SECURITY NO.		DATE OF BIRTH	
						MONTH / DAY / YEAR		
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		OFFICE USE
					SON	DAUGHTER	
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: _____