CSEA Employee Benefit Fund
Remove Dependent Form

To amend your enrollment record, please complete and sign the form below and return it to the address below.

Your prompt response will ensure that your benefit records are accurate so that claims can be processed without delay. Thank you for your cooperation.

EMPLOYEE INFORMATION (PLEASE PRINT)

Member's Name _____ EBF ID# _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Email _____

DEPENDENT TO BE REMOVED

Name _____

Address _____

Relationship to Employee _____

Reason for Ineligibility ☐ Legal Separation/Divorce * ☐ Death ☐ Other: _____

If this statement is to remove your spouse, you must provide a copy of the first and last page of the divorce/separation papers, or a letter from an attorney indicating that you are legally separated or divorced, and provide the date this became effective.

Date dependent became ineligible _____

I certify that the above information is correct:

Member's Signature _____ Date _____

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

MAIL COMPLETED FORM TO

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