Personnel Department

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AUTHORIZATION FOR PAYROLL DEDUCTION FOR VOLUNTARY DENTAL EFFECTIVE 07/01/2021-06/30/2022

Effective Date: _____

I hereby authorize payroll deductions for the following Dental Insurance Plan with Essex County:

NOTE: Deductions are taken the first two (2) pay periods of each month. Premiums are due the month prior for the next month (i.e. deduction in January for February coverage).

SOLSTICE

The payroll deduction for this plan will be as follows: Rates effective for: 07/01/2021-06/30/2022 (Rates subject to change 06/30/2022)

☐ Individual Plan $48.69 per month
☐ 2 Person Plan $97.38 per month
☐ Family Plan $155.81 per month

☐ Pre-Tax Deduction
☐ After-Tax Deduction

_____

Print Name **Date**

_____

Employee Signature

Solstice

ENROLLMENT FORM

Please indicate the plan(s) and coverage you are electing:

DENTAL	VISION
Please (✓) one:	Please (✓) one:
☐ Individual	☐ Individual
☐ Two Person	☐ Two Person
☐ Family	☐ Family

CSEA EMPLOYEE BENEFIT FUND
PO Box 516
Latham NY 12110
www.cseaebf.com
800-323-2732

Social Security # _____ Date of Birth ____/____/____

Name (First, Middle Initial, Last) _____ Please (✓) one: ☐ Male ☐ Female

Street Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Name of Employer _____

Please (✓) one: ☐ Spouse ☐ Domestic Partner* Date of Marriage _____/_____/_____ Please (✓) one: ☐ Male ☐ Female

Date of Birth _____/_____/_____ Social Security # _____

Name (First, Middle Initial, Last) _____

First Name_____Last Name_____Date of Birth ____/____/____ ☐M ☐F Relationship_____

First Name_____Last Name_____Date of Birth ____/____/____ ☐M ☐F Relationship_____

First Name_____Last Name_____Date of Birth ____/____/____ ☐M ☐F Relationship_____

Do you and/or your dependents have other dental coverage available? Please (✓) one: ☐ Yes ☐ No

If yes, please indicate: Name of other plan: _____Effective Date: ____/____/____

- Not all employers allow domestic partner coverage. Before enrollment of a domestic partner can be completed, the CSEA EBF must receive eligibility confirmation from your employer. For purposes of IRS reporting, it is necessary that you provide your domestic partner's social security number on this form.
- When enrolling dependent children, it may be necessary for the CSEA EBF to require and/or request additional information which may include full-time student verification for children ages 19 and over, verification of eligibility by "Proof of Dependency" form, copy of Birth Certificate and/or "Certification of Disability" form.
- In certain instances, a copy of a Marriage Certificate may be requested for proof of eligibility.

For a detailed outline of eligibility rules, please refer to your Summary Plan Description or visit our website at www.cseaebf.com

I certify that the above information is correct and I agree to maintain enrollment for myself and any dependents enrolled for a period of at least 12 months, unless there is a qualifying event.

Would you like this benefit Pre-Tax, if offered through your employer? ☐ Yes ☐ No

Employee Signature _____ Date _____