CSEA Employee Benefit Fund
Local Government Domestic Partner Approval

Health Benefits Administrators must use this form to approve domestic partner coverage for their employees.

Employee Information (Please Print)

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

Name (First, Middle Initial, Last) _____ ❑ M ❑ F please (✓)

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Domestic Partner Information

Domestic Partner Name _____ ❑ M ❑ F please (✓)

Social Security # _____ Effective Date of Coverage _____

Approval

Signature of Health Benefits Administrator/Management _____

Title _____ Today's Date _____ Phone Number _____

Important Information

This form does not automatically enroll a domestic partner. Once a domestic partner is approved, the EBF will send an enrollment form directly to the member to add their domestic partner to their EBF benefits.

Completed forms can be sent to:

Fax: 518-786-3658
Scan and Email: ole@cseaebf.org

For questions regarding this form our Member Services Department can be reached at 800-323-2732 press 5 then press 4.