CSEA
AFSCME Local 1000, AFL-CIO
EMPLOYEE
BENEFIT FUND

Date: _____

Dear CSEA EBF Member:

We have recently received a request to remove a dependent from your coverage under the CSEA Employee Benefit Fund. Before we can amend your enrollment record, we require a signed statement from you. Please complete the form below and return it to the Fund in the envelope provided. **If this request is to remove your spouse, you must provide a copy of divorce/separation papers or a letter from an attorney indicating that you are legally divorced or separated.**

Your prompt response will insure that your benefit records are accurate so that claims can be processed without delay.

Thank you for your cooperation.

CSEA Employee Benefit Fund
Enrollment/Eligibility Unit
PO Box 516
Latham, NY 12110-0516

REMOVE DEPENDENT FORM

EMPLOYEE INFORMATION:

Name:_____ EBF ID#_____

Address:_____

DEPENDENT TO BE REMOVED

Name:_____

Address:_____

Relationship to Employee:_____

Reason for Ineligibility_____

Date Dependent became ineligible:_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT

_____ _____

Employee Signature Date