PSEA PENNSYLVANIA STATE EDUCATION ASSOCIATION

PSEA Health and Welfare Fund
Enrollment Card
(Please type or print)

Effective Date: ______________

EMPLOYEE NAME: ______________________________ S.S. #______________

LAST FIRST MIDDLE INITIAL

HOME ADDRESS: ______________________________

STREET CITY STATE ZIP

EMPLOYEE PHONE #

SCHOOL DISTRICT (EMPLOYER) Lebanon School District

DATE OF BIRTH			
DATE MARRIED			
DATE EMPLOYED			

MARITAL STATUS
- ☐ MARRIED
- ☐ SINGLE
- ☐ DIVORCED
- ☐ WIDOWED

SEX
- ☐ MALE
- ☐ FEMALE

- ☐ NEW ENROLLMENT
- ☐ REINSTATEMENT
- ☐ CHANGE MARITAL STATUS
- ☐ CHANGE DEPENDENT STATUS
- ☐ NAME CHANGE
- ☐ ADDRESS CHANGE

ENROLLMENT TYPE
- ☐ EMPLOYEE ONLY
- ☐ TWO PARTY
- ☐ FAMILY

Employee pays differential for dependent coverage.

Dependents must remain enrolled until the following open enrollment unless there is a qualifying life event.

LIST YOUR ELIGIBLE DEPENDENTS, including spouse, if applicable (full names). Use another enrollment card if more space is needed.

* If Delete, list reason for deletion:

Add	*Del	LAST FIRST MI	SEX	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY #

I CERTIFY THAT THE STATEMENTS MADE HEREIN ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

EMPLOYEE'S SIGNATURE ______________________________ DATE: ______________