



Date: \_\_\_\_\_

Dear: \_\_\_\_\_

We 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 Unit, P.O. Box 516  
Latham, NY 12110-0516

EMPLOYEE INFORMATION:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Social Security No: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**DEPENDENT TO BE REMOVED**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Relationship to Employee: \_\_\_\_\_

Ineligible because (divorce, death, etc.): \_\_\_\_\_

Date Dependent became ineligible: \_\_\_\_\_

**I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
DATE

