



**CSI INSURANCE PLAN
AND TRUST FUND**

**INSURANCE LIMITED BENEFIT
EMPLOYEE APPLICATION FORM**

Employee Status : New Hire _____ COBRA _____ Retiree _____ Adding Dependent _____ Deleting Dependent _____
Effective Date _____ If deleting a dependent (s), which dependent (s) is being deleted? _____

Employee's Name _____ Soc. Sec. No. _____
Address _____ City _____ State _____ Zip _____
Phone Number _____ Date of Employment _____ Sex: M _____ F _____
Date of Birth _____ Single _____ Married _____ School _____

Beneficiary's name _____ Soc. Sec. No. _____ Relationship _____
Beneficiary's address _____ City _____ State _____ Zip _____

I would like the following coverage:

_____ Single Limited Benefit (includes Life, AD&D, and LTD) with dental _____ Single Limited Benefit without dental
_____ Family Limited Benefit (includes Life, AD&D and LTD) with dental _____ Family Limited Benefit without dental
_____ I am currently covered for dental under my spouse's employer plan.
_____ I have been given the opportunity to participate in the insurance benefit plan, but am refusing all coverage. *

If choosing Family Limited Benefit (include spouse and all dependent children), please list each eligible dependent:

1. Name _____ Birth Date _____ Sex _____ SSN _____ Relationship _____
2. Name _____ Birth Date _____ Sex _____ SSN _____ Relationship _____
3. Name _____ Birth Date _____ Sex _____ SSN _____ Relationship _____
4. Name _____ Birth Date _____ Sex _____ SSN _____ Relationship _____

I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that the carrier may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense. I hereby certify that I am eligible to participate and that to the best of my knowledge the information given above is correct and true to fact. (For information on eligibility, see below) Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff or leave of absence on the date that the insurance would otherwise become effective. For dependents: Insurance coverage will be delayed if that dependent is totally disabled on the date that the insurance would otherwise be effective. Exception: Infants are insured from live birth.

Signed _____ Date _____

ELIGIBILITY:

- a. All educational employees who work 500 or more classroom hours per Plan Year must participate in the Plan as of the date of their employment or at the time the school begins participation. All other employees who work 20 or more hours per week (at least 1,000 hours in a Plan Year) are eligible to participate.
- b. * At least 90% of all eligible employees must be enrolled.

Please have your Employer complete. Yearly salary _____ School Number 5439- _____