PSEA
PENNSYLVANIA STATE EDUCATION ASSOCIATION

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

*Effective date:*_____

EMPLOYEE NAME_____ S.S. NO._____
LAST FIRST MIDDLE

HOME ADDRESS_____
STREET CITY STATE ZIP

SCHOOL DISTRICT (EMPLOYER)_____

| | MONTH | DAY | YEAR |
|---|---|---|---|
| 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 ☐
***ADD or DELETE in the space below***

NAME CHANGE ☐
ADDRESS CHANGE ☐
***REASON FOR DELETION***
_____
_____

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

| | LAST | FIRST | MIDDLE | 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_____