NINTH JUDICIAL COURT EMPLOYEES ASSOCIATION WELFARE FUND
ENROLLMENT FORM

PLEASE COMPLETE, SIGN AND RETURN TO:
NJDCEA Welfare Fund
170 Hamilton Ave, Ste 206
White Plains, NY 10601

SECTION I MEMBER INFORMATION

SOCIAL SECURITY NUMBER	DATE OF BIRTH
☐☐☐-☐☐-☐☐☐☐	☐☐/☐☐/☐☐

LAST NAME	FIRST NAME	MI	PHONE	EMAIL

ADDRESS	APT NO.	CITY	STATE	ZIP

GENDER: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED

EMPLOYMENT IN THE NYS-OCA SYSTEM COMM3NCE DATE_____ WORK LOCATION ☐ WESTCHER ☐ ROCKLAND

EMPLOYMENT IN WESTCHESTER/ROCKLANDS COURT COMMENCE DATE_____

JOB LOCATON ☐ COMBINED COURT ☐ LAW LIBRARY ☐ FAMILY COURT ☐ COMMISSIONER OF JURORS ☐ SURROGATES

SECTION II SPOUSE INFORMATION-PLEASE ATTACH MARRIAGE CERTIFICATE

FIRST NAME	LAST NAME	MI	DATE OF BIRTH	SOC SEC NO.

IS SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES EMPLOYER NAME:_____

DOES THIS EMPLOYER PROVIDE A **DENTAL** PROGRAM? ☐ YES ☐ NO **OPTICAL** BENEFIT PROGRAM? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE NAME AND ADDRESS OF
INSURANCE COMPANY/ PLAN ADMINISTRATOR:

SECTION III DEPENDENT CHILD INFORMATION - PLEASE ATTACH BIRTH CERTIFICATE

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
	☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
	☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
	☐☐/☐☐/☐☐		☐☐/☐☐/☐☐

SECTION IV MEMBER SIGNATURE

I HEREBY CERTIFY THAT ALL THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A DENIAL OR SUSPENSION OF BENEFITS. IN ADDITION, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

MEMBER'S SIGNATURE:_____ DATE:_____/_____/_____

FOR OFFICE USE ONLY

VERIFICATION BY:_____ DATE:____/____/____ ELIGIBILITY START DATE:____/____/____