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 ❑
NAME CHANGE ❑
ADDRESS CHANGE ❑
ADD or DELETE in the space below

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_____