Service Employees Benefit Fund (SEBF)
SYRACUSE UNIVERSITY
Enrollment/Payroll Authorization Form
PO Box 1240, Syracuse, NY 13201
(315) 218-6513 or (855) 835-9720 Toll Free

Coverage Effective Date: _____

To enroll for Weekly Disability, please complete this form and return it to SEBF at the above address.

Employee Name (Last, First, MI)	Male/ Female	Social Security Number	SUID	Date of Birth	Date of Hire

Address (Street, City, State, Zip)	Phone Number

I authorize my employer to deduct my portion of the monthly premium from my paycheck and remit it to the Service Employees Benefit Fund as designated below.

Weekly Disability There is a **SIX-MONTH** premium paid waiting period before you are eligible for benefits.	**Please mark appropriate box below (X)** Please check one option only	**Total monthly premium Effective 1/1/17-12/31/17**
WITH Dental		$20.17
WITHOUT Dental		$24.63

I understand that if the entire premium is not paid each month, my eligibility for coverage may be terminated and that this option will remain in effect for a minimum of twelve (12) months unless changed or revoked by me thereafter during an open enrollment period. I also understand that the above premiums are subject to change as determined by the SEBF Board of Trustees.

Signature_____ Date _____