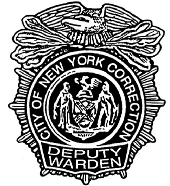
RETURN TO:
ADMINISTRATIVE SERVICES ONLY, INC.
Department 66-S
PO Box 9005
Lynbrook, NY 11563

(516) 396-5500 / (718) 204-7172

ASSISTANT DEPUTY WARDENS DEPUTY WARDENS ASSOCIATION
SECURITY BENEFITS FUND
ENROLLMENT FORM



SOCIAL SECURITY NUMBER: - -	EMPLOYEE REFERENCE #:	DATE APPOINTED TO DOC:	DATE PROMOTED TO: ADW: _____ DW: _____ DWIC: _____
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	BIRTH DATE:

ADDRESS:	APT #:	CITY:	STATE:	ZIP CODE:
EMAIL: (Non-DOC):		CELL PHONE NUMBER: ( ) -		TELEPHONE NUMBER: ( ) -

SPOUSE INFORMATION - PLEASE ATTACH A COPY OF YOUR MARRIAGE CERTIFICATE

LAST NAME:	FIRST NAME:	MI:	BIRTH DATE:	SOCIAL SECURITY #: - -
EMPLOYER'S NAME:				TELEPHONE NUMBER: ( ) -

EMPLOYER'S ADDRESS:	SUITE:	CITY:	STATE:	ZIP CODE:

IS YOUR SPOUSE COVERED BY ANOTHER:	IF YES, NAME OF INSURANCE COMPANY
(A) DENTAL BENEFIT PROGRAM? ☐ YES ☐ NO	
(B) OPTICAL BENEFIT PROGRAM? ☐ YES ☐ NO	

DEPENDENT INFORMATION - COPIES OF BIRTH CERTIFICATES, ADOPTION CERTIFICATES, OR PROOF OF LEGAL GUARDIANSHIP MUST BE ATTACHED. IF CHILD IS BETWEEN 19 AND 26 YEARS OF AGE, VERIFICATION MUST ALSO BE ATTACHED.

NAME	DATE OF BIRTH	SOCIAL SECURITY #	FULL-TIME STUDENT	IF YES, SCHOOL NAME
		- -	☐ YES ☐ NO	
		- -	☐ YES ☐ NO	
		- -	☐ YES ☐ NO	
		- -	☐ YES ☐ NO	
		- -	☐ YES ☐ NO	

BENEFICIARIES UPON DEATH. PLEASE PROVIDE COMPLETE NAMES AND ADDRESSES

PRIMARY BENEFICIARY	RELATIONSHIP	ADDRESS
SECONDARY BENEFICIARY	RELATIONSHIP	ADDRESS
TERTIARY BENEFICIARY	RELATIONSHIP	ADDRESS

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 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 SIGNATURE: ______________________ DATE _____/_____/_____ ELIGIBILITY START DATE: _____/_____/_____