SOUTHERN CALIFORNIA IBEW-NECA TRUST FUNDS
6023 Garfield Avenue, City of Commerce, CA 90040
Phone: (323) 221-5861 or (800) 824-6935
Fax: (323) 726-3520

Mailing Address:
P. O. Box 910918
Los Angeles, CA 90091

Website: www.scibew-neca.org
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SOUTHERN CALIFORNIA IBEW-NECA RETIREE HEALTH PLAN

FAMILY ACCOUNT CHANGE FORM

Return by: ______________ **Date sent: ____________________**

A determination on eligibility will be made following receipt by the Fund Office of the completed application.

Local No. ___________________________________

Name ____ Social Security No. ___________________________________
(Last) (First) (Middle)

Address ____
(Street) (City) (State) (Zip)

Telephone (______)____ Date of Birth ____

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Date of Marriage: ______________________________

Any necessary documentation not already on file with the Trust Fund office will be requested upon processing of this enrollment.

Please complete information below

FAMILY INFORMATION – Please list eligible family members to be enrolled or disenrolled.

	Last Name	First Name	M.I.	Social Security Number	Date of Birth
YOU					
SPOUSE					

***Please enclose the following information:**

☐ Marriage Certificate
☐ Copy of Entire Divorce Decree
☐ Family Account Change Form
☐ Positive Enrollment Form

Please return the Family Account Change form, Positive Enrollment form & a copy of your Marriage Certificate or Divorce Decree.

If your spouse is totally disabled, or enrolled in Medicare A and/or B, please indicate: ☐ Totally Disabled Medicare ☐ A ☐ B [*Please provide copy of card]*

Name: ____ Effective date: _________________________________

X____
Participant Signature Printed Name Date Signed

X____
Spouse Signature Printed Name Date Signed

Office Use Only: Current Eligibility: ___________________ Effective Date: ____________________ Initials/Date: ______________________

Comments: ____