

FAMILY ACCOUNT CHANGE FORM – RETIREE HEALTH PLAN

SOUTHERN CALIFORNIA IBEW-NECA HEALTH PLAN

100 Corson Street, Suite 200, Pasadena, CA 91103

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USE THIS FORM TO ADD OR TERMINATE YOUR SPOUSE'S HEALTH COVERAGE

PART 1: RETIREE INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NUMBER																	
STREET ADDRESS – DO NOT USE P.O. BOX			APT #:	CITY	STATE	ZIP CODE														
DATE OF BIRTH			TELEPHONE NUMBER ()						GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE											

PART 2: ELIGIBILITY STATUS DISCLAIMER (INITIALS REQUIRED)

RETIREE'S INITIALS REQUIRED _____	<p>I understand that if I subsequently remarry because of the death of my spouse or divorce, my new spouse will not be eligible for Retiree Health coverage unless I enroll my new spouse under this Plan by the end of the second calendar month following the date of marriage.</p> <p>I understand that the Southern California IBEW-NECA Health Trust Fund Board of Trustees reserves the right to require additional proof at any time of ongoing dependent eligibility and may conduct periodic audits to confirm eligibility status of all dependents.</p>
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PART 3: ADD SPOUSE – SEE LIST OF ELIGIBLE PLAN PARTICIPANTS AND REQUIRED DOCUMENTATION

REQUEST: <input type="checkbox"/> ADD SPOUSE <input type="checkbox"/> CERTIFIED MARRIAGE CERTIFICATE ENCLOSED	RELATIONSHIP: <input type="checkbox"/> SPOUSE – FEMALE <input type="checkbox"/> SPOUSE – MALE	DATE OF BIRTH:	
FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NUMBER:
DATE OF MARRIAGE:	FOR UNITEDHEALTHCARE PARTICIPANTS ONLY, INDICATE PRIMARY PHYSICIAN CARE CODE:		

PART 4: IF YOUR SPOUSE IS TOTALLY DISABLED OR ENROLLED IN MEDICARE A AND/OR B, PLEASE COMPLETE:

SPOUSE'S FIRST NAME	SPOUSE'S MIDDLE INITIAL	SPOUSE'S LAST NAME	<input type="checkbox"/> COPY OF MEDICARE CARD INCLUDED
<input type="checkbox"/> TOTALLY DISABLED	MEDICARE <input type="checkbox"/> A <input type="checkbox"/> B	MEDICARE NUMBER OR HICN NUMBER:	

PART 5: NAME CHANGE – PLEASE INCLUDE A COPY OF SOCIAL SECURITY CARD INDICATING NEW NAME

<input type="checkbox"/> NAME CHANGE – PARTICIPANT <input type="checkbox"/> NAME CHANGE - FAMILY	FIRST NAME	M.I.	LAST NAME
<input type="checkbox"/> COPY OF SOCIAL SECURITY CARD ENCLOSED <input type="checkbox"/> COPY OF DRIVER'S LICENCSE ENCLOSED	FORMER FIRST NAME	M.I.	FORMER LAST NAME

CONTINUE ON PAGE 2 ►

RETIREE INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NUMBER
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PART 6: IF TERMINATING SPOUSE, YOU MUST COMPLETE BELOW AND COMPLETE PAGE 2**

REQUEST: <input type="checkbox"/> TERMINATE SPOUSE <input type="checkbox"/> FINAL DISSOLUTION OF MARRIAGE ENCLOSED <input type="checkbox"/> DEATH CERTIFICATE ENCLOSED	RELATIONSHIP: <input type="checkbox"/> SPOUSE – FEMALE <input type="checkbox"/> SPOUSE – MALE	EFFECTIVE DATE OF DIVORCE OR LEGAL SEPARATION:	
FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF DEATH (IF APPLICABLE):
EX-SPOUSE'S FORWARDING ADDRESS:			SOCIAL SECURITY NUMBER:

PART 7: RETIREE'S SIGNATURE REQUIRED

RETIREE SIGNATURE	RETIREE NAME PRINTED	DATE SIGNED
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PART 8: **IMPORTANT INFORMATION ABOUT TERMINATION OF COVERAGE FOR SPOUSE**

RETIREE'S INITIALS REQUIRED _____	<p>VOLUNTARY TERMINATION: At any time, you and your spouse can terminate your spouse's participation in the Retiree Health Plan. To terminate your spouse's coverage, you must give the Administrative Office 30 days advance notice, by letter or by completing this form, signed by you and your spouse.</p> <p>This document must have <u>both</u>, the Retiree and Spouse's signature, notarized. Once terminated, a spouse <u>will not be permitted to re-enroll</u> in the Retiree Health Plan. Please refer to the Summary Plan Description for more details.</p>
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PART 9: RETIREE AND SPOUSE'S SIGNATURE MUST BE NOTARIZED IF TERMINATING COVERAGE FOR SPOUSE ***

State of California, County of _____

On _____ before me, _____ before me appeared _____ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledge to me that he/she/they executed the same in the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

Witness my hand and official seal.

Notary Public Signature

SEAL

RETIREE SIGNATURE	RETIREE NAME PRINTED	DATE SIGNED
SPOUSE'S SIGNATURE	SPOUSE'S NAME PRINTED	DATE SIGNED

FOR OFFICE USE ONLY							
NOTES	REASON	MEDICAL	DENTAL	EFFECTIVE DATE OF COVERAGE			DOCUMENTS RECEIVED
	<input type="checkbox"/> ADDING SPOUSE <input type="checkbox"/> TERMINATING SPOUSE <input type="checkbox"/> NAME CHANGE			MONTH	DAY	YEAR	DATE RECEIVED: _____ BY: _____ <input type="checkbox"/> MARRIAGE CERT <input type="checkbox"/> DISSOLUTION OF JUDGMENT <input type="checkbox"/> SOCIAL SECURITY CARD <input type="checkbox"/> MEDICARE CARD

ADDITIONAL INFORMATION:

LIST OF ELIGIBLE DEPENDENTS UNDER THE RETIREE HEALTH PLAN:	PLEASE INCLUDE THE REQUIRED DOCUMENTATION WITH THIS ENROLLMENT FORM:
SPOUSE	COPY OF CERTIFIED MARRIAGE CERTIFICATE
FORMER SPOUSE	COPY OF JUDGMENT OF DISSOLUTION, LEGAL SEPARATION OR ANNULMENT
NAME CHANGE	COPY OF SOCIAL SECURITY CARD AND NEW DRIVER'S LICENSE

SAMPLE OF ACCEPTABLE DOCUMENTS BELOW:

Marriage Certificate
 A certified marriage certificate proves you did get married and recorded with the county clerk's office. This is an approved verification document.



Marriage License
 A marriage license only proves you filed for a license and is **NOT** an approved verification document.

