Southern California IBEW-NECA Health Plan
6023 Garfield Ave.
City of Commerce, CA 90040
(323) 221-5861 or (800) 824-6935 Nationwide

MEDICAL/DENTAL/Vision COVERAGE ENROLLMENT FORM – DISABILITY RETIREES

******PLEASE TYPE OR PRINT – RETURN TO HEALTH PLAN OFFICE******

Last Name	First Name	M.I.	SOCIAL SECURITY NUMBER				–		–				
Street Address – Do **NOT** use P.O.Box	Apt. #	City	State	Zip Code	Phone Number ( )								
Local # **11**	Active ☐ Retiree ☐	Male ☐ Female ☐	Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐		Date of Marriage								

MEDICAL – Select one plan only

I. ☐ Kaiser Permanente HMO – Group 1155 – 01 ☐ Pacificare HMO – Group 144787/144788/4257

DENTAL – Select one plan only

☐ CIGNA ☐ Delta ☐ Safeguard ☐ United Concordia ☐ Self-Funded Dental (Allied)

II. After selecting your plan, please complete information below. **VISION** □ Please mark an "x"

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

This section must be completed if you have selected Pacificare. ↓

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	Pacificare Primary Care Physician Code									Is this your current MD?
YOU				- -	/ /										☐☐ Y N
SPOUSE				- -	/ /										☐☐ Y N

If you or your spouse are totally disabled, or enrolled in Medicare A and/or B, please indicate.
Name _____ □ Totally Disabled Medicare A □ B □

If you or your spouse have other insurance, please complete:
Name of other insurance _____ Policy # _____ Insured Name _____

FOR OFFICE USE ONLY

CURRENT ELIGIBILITY:	EFFICTIVE DATE:
COMMENTS:	

I understand this election will remain in effect so long as I remain eligible, or until I make another election during an open enrollment period. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, or Pharmacist to release any information requested to pay any claim under the plan selected. I want to enroll myself and those eligible members of my family listed above for participation in the plan elected. I understand that it is my responsibility to report any change in the eligibility of my dependents; that the benefits and services of the elected plan are coordinated with those provided by any other group hospital, medical benefit, dental plan or service plan. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any plan (Kaiser or Pacificare) member and any such plan (including its agents, staff physicians, employees and providers) is subject to binding arbitration.

RETIREE SIGNATURE	DATE SIGNED