SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND – RETIREE
6023 Garfield Avenue, City of Commerce, CA 90040
Phone: (323) 221-5861 or (800) 824-6935
Fax: (323) 726-3520 Website: www.scibew-neca.org
Mailing Address: P.O. Box 910918, Los Angeles, CA 90091

RETIREE HEALTH PLAN
ENROLLMENT FORM

PLEASE TYPE OR PRINT – RETURN TO ADMINISTRATIVE TRUST FUNDS 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 #							Date of Marriage
11	Male ☐ Female ☐	☐ Single	☐ Married	☐ Legally Separated	☐ Divorced	☐ Widowed	

I.

Options	☐ **Normal Retirees**	☐ **Early Retirees**	☐ **Disability Retirees**
Medical (Select one plan)	☐ Kaiser Permanente Senior Advantage (HMO) ☐ UnitedHealthcare Secure Horizons (HMO) ☐ Premium Reimbursement ☐ Medicare Supplement	☐ Kaiser Permanente (HMO)- Group 101155-01 ☐ UnitedHealthcare (HMO) – Group 144787 ☐ Premium Reimbursement	☐ Kaiser Permanente (HMO) - Group 101155-01 ☐ UnitedHealthcare (HMO) – Group 144787/144788/004257 ☐ Premium Reimbursement ☐ Medicare Supplement
DENTAL (Select one plan) Applicable only to Disability Retirees	**N/A** Contact your selected medical provider	**N/A**	☐ United Concordia (PPO) ☐ Cigna (DHMO) ☐ DeltaCare (DHMO) ☐ MetLife/Safeguard (DHMO) ☐ United Concordia (DHMO)

II. After selecting your plan, please complete information below.

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

This section must be completed if you have selected UnitedHealthcare

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	UnitedHealthcare 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 are enrolled in Medicare A and/or B, please include a copy of your Medicare card *****

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

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 UnitedHealthcare) member and any such plan (including its agents, staff physicians, employees and providers) is subject to binding arbitration.

RETIREE SIGNATURE	DATE SIGNED

FOR OFFICE USE ONLY

CURRENT ELIGIBILITY:	EFFECTIVE DATE:
COMMENTS:	