

Southern California IBEW-NECA Health Plan - ACTIVE
 6023 Garfield Avenue, City of Commerce, California 90040
 Mailing Address: P.O. Box 910918, Los Angeles, CA 90098-9341
 (323) 221-5861 or (800) 824-6935 (Nationwide)
 Fax No.: (323) 726-3520 Web: www.scibew-neca.org

MEDICAL AND DENTAL PLAN ENROLLMENT FORM - ACTIVE

** Please print or type clearly **

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	Male † Female †	Single †	Married †	Legally Separated †	Divorced †	Widowed †	Domestic Partner (DP) †		Date of Marriage										

MEDICAL (Select one Plan)		
† Anthem Blue Cross Prudent Buyer(PPO) Group 170001M004	† Kaiser Permanente(HMO) Group 101155	UnitedHealthcare (HMO) Group 144786

DENTAL										
PLAN Select one Plan only		Indicate Facility Number form directory if selecting a DHMO: DeltaCare, CIGNA, United Concordia or MetLife/Safeguard						Previous member of this plan?		
								YES	NO	WHEN (last year)?
	United Concordia (PPO) 894200-00									
	DeltaCare (DHMO) 01175-001									
	CIGNA Dental Care (DHMO) 3217300									
	United Concordia (DHMO) 740284									
	MetLife/Safeguard Dental (DHMO) 74328									

II. After selecting your Plan, please complete information below on all eligible dependents.

FAMILY INFORMATION Please list all eligible family members to be enrolled. Please provide a copy of a marriage certificate or Affidavit & Declaration of Domestic Partnership , and/or birth certificates or certificate of live births.						This section must be completed if You have selected UnitedHealthcare							
	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 †DP				- -	/ /								† † Y N
†Son †Daughter				- -	/ /								† † Y N
†Son †Daughter				- -	/ /								† † Y N
†Son †Daughter				- -	/ /								† † Y N
†Son †Daughter				- -	/ /								† † Y N

Please provide copies of marriage certificate and/or all eligible dependent birth certificate or certificate of live birth. For Domestic Partnership please submit the Affidavit & Declaration of Domestic Partnership for Enrollment in Plan.
 If you or any family members are: totally disabled, enrolled in Medicare A and/or B.

Name _____ †Totally Disabled Medicare †A †B †Full-time Student

If you or any eligible family members 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 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 changes in the eligibility of my dependents; that the benefits and services of the elected plans 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 Permanente, PacifiCare, Anthem Blue Cross, DeltaCare, United Concordia, MetLife/Safeguard, Cigna Dental) member and any such Plan (including its agents, staff physicians, employees and providers) is subject to binding arbitration.

Participant Signature	Date Signed
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***** FOR OFFICE USE ONLY *****

CURRENT ELIGIBILITY:	EFFECTIVE DATE:
COMMENTS:	