

Southern California IBEW-NECA Health Plan

6023 Garfield Avenue
 City of Commerce, California 90040
 Mailing Address: P.O. Box 910918, Los Angeles, CA 90091
 (323) 221-5861 or (800) 824-6935 (Nationwide)

HEALTH AND DENTAL PLAN

FAMILY ACCOUNT CHANGE FORM
 www.scibew-neca.org
 (323) 726-3520 Fax No.

PARTICIPANT INFORMATION				Social Security Number	-	-	-	-	-	-	
Last Name						First Name				MI	
Street Address – Do NOT use P.O. Box						Apt. No.		City			
State	Zip Code	Phone ()		Birthdate		<input type="checkbox"/> Active		<input type="checkbox"/> Retired			

Signature	Date
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FAMILY MEMBER ADD/DROP (for a drop, must also complete Sections A & B below)

Check Health Plan		<input type="checkbox"/> PacifiCare/United Health Care (HMO) <input type="checkbox"/> Anthem/Blue Cross Prudent Buyer (PPO) <input type="checkbox"/> Kaiser Permanente (HMO) *Kaiser only – write in Family Account No. _____				Check Dental Plan		<input type="checkbox"/> United Concordia <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> DeltaCare DHMO <input type="checkbox"/> CIGNA Dental <input type="checkbox"/> Safeguard Dental		
ADD	DROP	Relationship (Check Box)	Last Name	First Name	MI	Date of Birth	Social Security Number	Primary Care Physician/Office No. Dental/Medical Group (if CIGNA, DELTACARE, United Concordia or Safeguard)		
		<input type="checkbox"/> Wife* <input type="checkbox"/> Husband* <input type="checkbox"/> Domestic Partner								
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter								

IF ADDING A SPOUSE, A COPY OF A MARRIAGE CERTIFICATE MUST BE ATTACHED.
IF ADDING A DOMESTIC PARTNER, PLEASE CONTACT THE FUND OFFICE OR VIEW THE DOCUMENTATION REQUIREMENTS AT WWW.SCIBEW-NECA.ORG
IF DIVORCING A SPOUSE, A COPY OF A FINAL DIVORCE DECREE OR DEATH CERTIFICATE MUST BE ATTACHED. Ex-spouse Social Security No. _____
 Ex-Spouse address _____
 Number _____ Street _____ City _____ State _____ Zip Code _____

IF DROPPING DOMESTIC PARTNER, A NOTARIZED LETTER IN WRITING MUST BE SUBMITTED FROM BOTH PARTIES.
 Ex-Domestic Partner address _____
 Number _____ Street _____ City _____ State _____ Zip Code _____

IF ADDING A CHILD A COPY OF A CERTIFICATE OF LIVE BIRTH OR ADOPTION PAPERS MUST BE ATTACHED.
HAS DEPENDENT BEING ADDED BEEN A MEMBER OF THE HEALTH PLAN BEFORE? YES NO
IF DEPENDENT BEING ADDED IS OVER AGE 19 AND A FULL TIME STUDENT, YOU MAY DOWNLOAD THE FORM FROM WWW.SCIBEW-NECA.ORG OR CONTACT THE ADMINISTRATIVE OFFICE.

SECTION A – If you are dropping a family member, place a check by the appropriate reasons. <input type="checkbox"/> A divorced or legally separated spouse, effective date ____/____/_____ <input type="checkbox"/> Child no longer qualifies as a dependent, effective date ____/____/_____ <input type="checkbox"/> Other _____, effective date ____/____/_____.	SECTION B – Please indicate the current address of dependent(s) being dropped (attach additional page if more space is required). Address _____ City _____ State _____ Zip Code _____
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For name change, must attach notice that Social Security will use new name for their records.		NAME CHANGE			**PLEASE ALSO COMPLETE PARTICIPANT INFORMATION ABOVE**		
<input type="checkbox"/> MY NAME ONLY <input type="checkbox"/> ENTIRE FAMILY		Former Last Name			First Name		MI

FOR OFFICE USE ONLY							
Medical Group Number	Dental Group Number	Effective Date of Change			Document received with Form – Initials _____ Date _____		
		Month	Day	Year	<input type="checkbox"/> Marriage Certificate	<input type="checkbox"/> Adoption papers	<input type="checkbox"/> Divorce Decree
					<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Social Security name change	<input type="checkbox"/> Domestic Partner Affidavit
					<input type="checkbox"/> Death Certificate		