

Southern California IBEW-NECA Health Trust Fund

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)

ACTIVE
HEALTH AND DENTAL PLAN
FAMILY ACCOUNT CHANGE FORM
 www.scibew-neca.org
 Fax No. (323) 726-3520

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							
Signature								Date				

FAMILY MEMBER ADD/DROP										(for a drop, must also complete Sections A & B below)
ADD	DROP	Relationship (Check Box)	Last Name	First Name	MI	Date of Birth	Social Security Number	FOR PACIFICARE ONLY Primary Care Physician/Code		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wife* <input type="checkbox"/> Husband* <input type="checkbox"/> Domestic Partner								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter								

ADD: Please review this Section if adding a family member	
If adding a....	Required documents to submit with this form
Spouse	Copy of Marriage Certificate
Domestic Partner	Notarized Affidavit & Declaration of Domestic Partnership
Dependent child under age 19	Copy of birth certificate or adoption papers
Dependent child over age 19	Copy of birth certificate <u>and</u> completed Overage Dependent Certification Form

DROP: Please review this Section if dropping a family member	
If dropping a....	Required documents to submit with this form
Spouse	Copy of final Divorce Decree
Domestic Partner	Written acknowledgement from each party of termination of domestic partnership.**

** Both parties acknowledge responsibility for all losses to the Fund, (refer to signed Affidavit), should either fail to notify the Fund.

Please complete Sections A & B below and attach required documents

Has the dependent listed above ever been a member of this Health Plan? Yes No

Complete Sections A and B if dropping a Family Member, and include any required documentation along with this form.			
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 provide current information of dependent(s) being dropped (attach additional page if more space is required)	
		Name	
		Address	
		City	State Zip Code

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 <input type="checkbox"/> Overage Dependent Certification Form Written acknowledgement of termination of DP