

SOUTHERN CALIFORNIA IBEW-NECA RETIREE HEALTH PLAN

Return by: _____ **APPLICATION** **Date sent:** _____
A determination on eligibility will be made following receipt by the Fund Office of the completed application.

Local No. _____

Name _____
 (Last) (First) (Middle)

Social Security No. _____

Address _____
 (Street) (City) (State) (Zip)

Telephone (_____) _____ Date of Birth _____

Date of Marriage:

Male () Female () Single () Married () Divorced () Widowed () _____

Any necessary documentation not already on file with the Trust Fund office will be requested upon processing of this application.

Please complete information below.

| FAMILY INFORMATION – Please list eligible family members to be enrolled. | | | | | | |
|--|-----------|------------|------|------------------------|---------------|--|
| | Last Name | First Name | M.I. | Social Security Number | Date of Birth | |
| YOU | | | | | | |
| SPOUSE | | | | | | |

RETIREMENT – Check **one** only

() Application for participant taking early or normal retirement from Pension Fund

() Application for participant taking disability retirement.

If you or your spouse are totally disabled, or enrolled in Medicare A and/or B, please indicate: () Totally Disabled Medicare (A (B
Please provide a copy of your card.

Name: _____ Effective date: _____

X _____
 Participant Signature Printed Name Date Signed

X _____
 Spouse Signature Printed Name Date Signed

| | | | |
|-------------------------|----------------------------|-----------------------|----------------------|
| Office Use Only: | Current Eligibility: _____ | Effective Date: _____ | Initials/Date: _____ |
| Comments: _____ | | | |