### FAMILY ACCOUNT CHANGE FORM - RETIREE HEALTH PLAN

#### **SOUTHERN CALIFORNIA IBEW-NECA HEALTH PLAN**

100 Corson Street, Suite 200, Pasadena, CA 91103

Mailing Address: P.O. Box 6652, Pasadena, CA 91109

(323) 221-5861 or (800) 824-6935 (Nationwide) Fax No.: (323) 726-3520 website: www.scibew-neca.org

USE THIS FORM TO ADD OR TERMINATE YOUR SPOUSE'S HEALTH COVERAGE														
PART 1: RETIREE INFORMATION														
FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURI NUMBI	ITY			_			-				
STREET ADDRESS	– DO NOT USE P.O. BOX	APT #: CITY	STA	ATE		Į.		ZIP	COD	ÞΕ	<u> </u>			<u> </u>
DATE OF BIRTH		TELEPHONE NUMBER		(	GENDE	R:	□ MA		_					
		( )					☐ FEN	VIAL	.E					
DADT O. FLI	CIDILITY CTATUC DICOLA	IMED (INITAL C DECUIDED)												
		IMER (INITALS REQUIRED)												_
RETIREE'S	RETIREE'S I understand that if I subsequently remarry because of the death of my spouse or divorce, my new spouse will not be													
INITALS	eligible for Retiree Health coverage unless I enroll my new spouse under this Plan by the end of the second calendar mont following the date of marriage.							ıtn						
REQUIRED														
	I understand that the Southern California IBEW-NECA Health Trust Fund Board of Trustees reserves the right to require additional proof at any time of ongoing dependent eligibility and may conduct periodic audits to confirm eligibility status													
of all dependents.								Jtu	tus					
PART 3: ADI	O SPOUSE - SEE LIST OF	ELIGIBLE PLAN PARTICIPANTS A	ND REC	QUIR	ED D	ocu	MEN	ΓΑΤ	ION	1				
	ADD SPOUSE CERTIFIED MARRIAGE CERTIFICATE ENCLOSED	RELATIONSHIP: ☐ SPOUSE – FEMALE ☐ SPOUSE – MALE				DATE OF BIRTH:								
FIRST NAME	MIDDLE IN	ITAL LAST NAME				SOCIAL SECURITY NUMBER:								
DATE OF MARR	IAGE:	FOR UNITEDHEALTHCARE PARTICIPANTS ONLY, INDICATE PRIMARY PHYSICIAN CARE CODE:												
DADT 4 IEN	YOUR OROUGE IS TOTALL	( DIGARI ED OR ENDOU ER IN ME	D104D			<u> </u>					D			
PART 4: IF YOUR SPOUSE IS TOTALLY DISABLED OR ENROLLED IN MEDICARE A AND/OR B, PLEASE COMPLETE:  SPOUSE'S FIRST NAME SPOUSE'S MIDDLE INITIAL SPOUSE'S LAST NAME COPY OF MEDICARE CARD INCLUDED														
SPOUSE STRICT INAIVILE SPOUSE STAST INAIVIE LICETT OF IVIEDICARE CARD INCLUDED														
☐ TOTALLY DIS	ABLED MEDICARE	ПА □В	MEDICARE NUMBER OR HICN NUMBER:											
PART 5: NAI	ME CHANGE – PLEASE IN	ICLUDE A COPY OF SOCIAL SECUP	RITY CA	RD I	INDIC	ATIN	IG NE	W	NA	ME				
□ NAME CHAN	NGE – PARTICIPANT NGE - FAMILY	FIRST NAME	M.I.	LA	LAST NAME									
	CIAL SECURITY CARD ENCLOSEI IVER'S LICENCSE ENCLOSED	FORMER FIRST NAME	M.I.	FC	FORMER LAST NAME									

**CONTINUE ON PAGE 2** ▶

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KELIKEEIN	IFORMATION					
FIRST NAME	MIDDLE INIT	AL	LAST NAME		SOCIAL SECU	RITY NUMBER
					Į.	
PART 6: IF	TERMINATING SPOUS	E, YOU M	UST COMPLETE BE	LOW AND C	OMPLETE PAGE	2**
REQUEST: E	TERMINATE SPOUSE		RELATIONSHIP: ☐ SPO			EFFECTIVE DATE OF DIVORCE
	FINAL DISSOLUTION OF		☐ SPO	USE – MALE		OR LEGAL SEPARATION:
_ ا	MARRIAGE ENCLOSED	OCED				
FIRST NAME	DEATH CERTIFICATE ENCL	LE INITAL	I	AST NAME		DATE OF DEATH (IF APPLICABLE):
TINSTIVALVIE	IVIIDD	LL IIVITAL	<u>.</u>	LAST IVAIVIL		DATE OF DEATH (II AFTERCADEL).
EX-SPOUSE'S F	ORWARDING ADDRESS:					SOCIAL SECURITY NUMBER:
DADT 7. DE	TIDEE'S SIGNATURE I		`			
	TIREE'S SIGNATURE	REQUIRE		<u> </u>		DATE CICNED
RETIREE SIGNA	ATURE		RETIREE NAME PRINTE	U		DATE SIGNED
					-	
PART 8: **	<b>IMPORTANT INFORM</b>	ATION AE	OUT TERMINATION	OF COVER	AGE FOR SPOU	SE***
						spouse's participation in the Retiree
RETIREE'S				-	-	e Office 30 days advance notice, by
INITIALS	letter or by completing	-		_		
REQUIRED	, ,	Ü	,	•		
	This document must	have <u>both</u>	, the Retiree and Spo	ouse's signatu	<b>ire, notarized</b> . On	ce terminated, a spouse will not be
	permitted to re-enroll	in the Reti	ree Health Plan. Plea	se refer to th	e Summary Plan D	escription for more details.
DADT O. DET	IDEE AND COOLEE'S SI	CNATURE	MUCT DE NOTADIZE	D IE TEDMINI	ATING COVEDAGE	FOR CROUCE ***
PART 9: RET	TREE AND SPOUSE'S SI	GNATURE	MUST BE NOTARIZE	D IF TERMINA	ATING COVERAGE	FOR SPOUSE ***
	TIREE AND SPOUSE'S SI	GNATURE	MUST BE NOTARIZE	D IF TERMINA	ATING COVERAGE	FOR SPOUSE ***
		GNATURE	MUST BE NOTARIZE	D IF TERMINA	ATING COVERAGE	FOR SPOUSE ***
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		GNATURE	MUST BE NOTARIZE	D IF TERMINA	ATING COVERAGE before me appea	
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ADDITIONAL INFORMATION:	
LIST OF ELIGIBLE DEPENDENTS	PLEASE INCLUDE THE REQUIRED DOCUMENTATION
UNDER THE RETIREE HEALTH PLAN:	WITH THIS ENROLLMENT FORM:
SPOUSE	COPY OF CERTIFIED MARRIAGE CERTIFICATE
	COPY OF JUDGMENT OF DISSOLUTION, LEGAL SEPARATION OR
FORMER SPOUSE	ANNULMENT
NAME CHANGE	COPY OF SOCIAL SECURITY CARD AND NEW DRIVER'S LICENSE

#### **SAMPLE OF ACCEPTABLE DOCUMENTS BELOW:**

# Marriage Certificate A certified marriage certificate proves you did get married and recorded with the county clerk's office. This is an approved verification document.



## Marriage License A marriage license only proves you filed for a license and is NOT an approved verification document.

