SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND – RETIREE
6023 Garfield Avenue, City of Commerce, CA 90040
Phone: (323) 221-5861 or (800) 824-6935
Fax: (323) 726-3520 Website: www.scibew-neca.org
Mailing Address: P.O. Box 910918, Los Angeles, CA 90091

RETIREE HEALTH PLAN
ENROLLMENT FORM

PLEASE TYPE OR PRINT – RETURN TO ADMINISTRATIVE TRUST FUNDS OFFICE

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 ☐	Date of Birth:	Single ☐	Married ☐ Date ______	Legally Separated ☐	Divorced ☐	Widowed ☐

Is there a language, other than English, that is your language of choice?:	No ☐	Yes ☐ Language: ______	Decline to respond ☐
For your spouse, is there a language, other than English, that is the language of choice?:	No ☐	Yes ☐ Language: ______	Decline to respond ☐

I.

Options	☐ **Normal Retirees**	☐ **Early Retirees**	☐ **Disability Retirees**
Medical (Select one plan)	☐ UHC-Medicare Advantage Plan – Group#13601 ☐ Medicare Supplement	☐ United Healthcare Out of Area—Group# 902027/355805	☐ United Healthcare CA Choice Plan (PPO) – Group# 902027/355805 ☐ UHC-Medicare Advantage Plan – Group# 13601 ☐ Medicare Supplement
DENTAL (Select one plan) Applicable only to Disability Retirees	**N/A** Contact your selected medical provider	**N/A**	☐ United Concordia (PPO)

II. After selecting your plan, please complete information below.

FAMILY INFORMATION – Please list eligible family members to be enrolled.

This section must be completed if you have ↓ selected UnitedHealthcare. ↓

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	UNITEDHEALTHCARE Primary Care Physician Code	Is this your current MD?
YOU				- -	/ /		☐ Yes ☐ No
☐ Female Spouse ☐ Male Spouse				- -	/ /		☐ Yes ☐ No

If you or your spouse are totally disabled, or enrolled in Medicare A and/or B, please indicate.
Name ______________________ ☐ Totally Disabled Medicare A ☐ B ☐

***** If you are enrolled in Medicare A and/or B, please include a copy of your Medicare card *****

If you or your spouse 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 (United Healthcare and United Concordia) member and any such Plan (including its agents, staff physicians, employees and providers) is subject to binding arbitration.

RETIREE SIGNATURE	DATE SIGNED

FOR OFFICE USE ONLY

Eligibility Date	Enrollment Reason	Medical Group	Retirement Effective Date	Effective Date of Change			Documents Received
	☐ New Enrollment ☐ Carrier Change			Month	Day	Year	Date Received: ______ By: ____ ☐ Marriage Certificate ☐ Medicare card