SOUTHERN CALIFORNIA IBEW-NECA TRUST FUNDS
100 Corson Street, Suite #200, Pasadena, CA 91103
Phone: (323) 221-5861 or (800) 824-6935
Fax: (323) 726-3520
Mailing Address:
P.O. Box 6652
Pasadena, CA 91109

Website: www.scibew-neca.org

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SOUTHERN CALIFORNIA IBEW-NECA RETIREE HEALTH PLAN

Return by:_____ APPLICATION Date sent: _____

The Administrative Trust Funds Office will make a determination on your eligibility following receipt of the completed application.

Last Name	First Name	M.I.	Social Security Number	Phone Number ( )
Street Address – **Do Not Use** P.O. Box Apt #	City	State	Zip Code	

Male ☐ Female ☐	Date of Birth:	Single ☐	Married ☐ Date _____	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 ☐

Any necessary documentation not already on file with the Administrative Trust Funds Office will be requested upon processing of this application.

Please complete information below:

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH
YOU					
☐ Female Spouse ☐ Male Spouse					

If you or your spouse are totally disabled or enrolled in Medicare A and/or B, please indicate: ☐ Totally Disabled Medicare ☐ A&B ☐ D
[*Please provide copy of Medicare 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: _____