NECA IBEW
LEADING THE ELECTRICAL INDUSTRY

HARRISON TRUST

A FAMILY HEALTH PLAN
WWW.HARRISONBENEFITS.ORG

ENROLLMENT FORM

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Open Enrollment** ☐ **Adding Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____ GENDER: (Circle One) Male Female

PHONE NUMBER: (_____) _____ EMAIL: _____

MEDICAL PLAN (CHOOSE ONE):	**DENTAL (CHOOSE ONE):**
☐ TRUST SELF-FUNDED PLAN ☐ KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST (**Active** Grp# 2454-10) ☐ PROVIDENCE HEALTH PLAN	☐ TRUST SELF-FUNDED ☐ KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ☐ WILLAMETTE DENTAL **Note:** Choice of coverage is offered to new employees or during Open Enrollment

Note: IF YOU, YOUR SPOUSE, OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

(**ATTACH LEGAL DOCUMENTATION** that applies: birth certificate(s), marriage certificate, adoption papers, guardianship papers, and divorce papers.)

FULL NAME	SSN	GENDER	DATE OF BIRTH	RELATIONSHIP

_____ _____

Signature Required for Kaiser Permanente Plan **Date**

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

MEMBER'S SIGNATURE _____ **DATE** _____

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