UNITE HERE!

SAN DIEGO UNITE-HERE TRUST FUNDS

ENROLLMENT FORM

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

EMPLOYEE'S FULL NAME:_____ SSN: _____

ADDRESS:_____ CITY: _____

STATE:_____ ZIP:_____ DATE OF BIRTH: _____

PHONE NUMBER: (_____)_____ GENDER: (Check One) Male_____ Female _____

MEDICAL PLAN (CHOOSE ONE):	**DENTAL PLAN (CHOOSE ONE):**
☐ BLUE CROSS PPO - **BASIC** (NO SELF-PAY REQUIRED) *EMPLOYEE ONLY COVERAGE – NO DEPENDENTS*	☐ FIRST DENTAL HEALTH
☐ BLUE CROSS PPO - **SELECT** ($20/MONTH SELF PAY REQUIRED)	☐ SIMNSA DENTAL (HMO)
☐ BLUE CROSS PPO - **PLUS** ($80/MONTH SELF PAY REQUIRED)	
☐ SIMNSA HMO (NO SELF-PAY REQUIRED)	

UNITE HERE Local 30 Family Health Center Election as Primary Care

☐ **I wish to elect the UNITE HERE Local 30 Family Health Center as my Primary Care Provider for Medical**
NOTE: This is only available if you elect one of the Blue Cross PPO options

☐ **I wish to elect the UNITE HERE Local 30 Family Health Center as my Primary Care Provider for Dental**
NOTE: This is only available if you elect First Dental Health

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

DEPENDENTS - (Including Spouse/Domestic Partner)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:
Birth Certificate(s) for children, Marriage Certificate for spouse, Certificate of Domestic Partnership, Legal Adoption papers, Legal Guardianship papers

Please check the box if your dependent wishes to use the UNITE HERE Local 30 Family Health Center as his/her PCP

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SSN	MED CLINIC	DEN CLINIC
		/ /	- -	☐	☐
		/ /	- -	☐	☐
		/ /	- -	☐	☐
		/ /	- -	☐	☐
		/ /	- -	☐	☐
		/ /	- -	☐	☐

I agree to notify the Trust 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 stating false or misleading information or the omission of material information could be grounds for denial of benefits.

MEMBER SIGNATURE_____ **DATE:** _____

3737 Camino Del Rio So., Suite 300, San Diego, CA 92108 • Phone 619-849-1060 • Fax 619-632-5682
www.unitehere30benefits.org • staff@uniteherebenefits.org

Coordination of Benefits

Member's Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____

☐ ***If you and/or spouse/dependents DO NOT have any other insurance coverage, please check this box turn over and sign/date the bottom of the next page (under "Member Statement").***

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

A MEMBER HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

B SPOUSE AND DEPENDENTS HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

1.) Dependent: _____

☐ **Medical/Rx** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

2.) Dependent: _____

☐ **Medical/Rx** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

Continuation on other Side

additional dependents, ATTACH A SEPARATE sheet with employee's name at top. (Last, First, MI)

Dependent: _____

☐ **Medical/Rx** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

C

FILL OUT THIS SECTION ONLY IF YOUR CHILD(REN) HAVE ADDITIONAL HEALTHCARE COVERAGE DUE TO •DIVORCE •SEPARATION •COURT ORDER •MEDICARE OR •OTHER FEDERAL-STATE HEALTH INSURANCE PROGRAMS.

*****(Indicate which child by marking appropriate circle) *****

1.) Is child(ren) covered by Medicare or other Federal-State coverage? □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

Medi-Cal/Medicaid: Policyholder name: _____ Policy Number: _____

2.) Does one parent/guardian have full custody of the child(ren): □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

3.) Is one parent required by court decree to provide health insurance for child(ren): □ Yes or □ No ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

Name of person responsible for child's healthcare coverage? _____

Employer: _____ Date of Birth: _____

Insurance Company name: _____ Insurance Company City & State: _____

Insurance Company Phone Number: _____ Enrollee ID/ policy number: _____

Group Number: _____ Effective date: _____ Cancellation date (if applicable): _____

******If court decree is present please PROVIDE A COPY of the court documents ******

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I am also aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers because of such material in any matter.

Signature: _____ **Phone #:** _____ **Date:** _____