Teamsters Local 631 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: _____ EMAIL: _____

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

MEDICAL PLAN (CHOOSE ONE):	**DENTAL PLAN (CHOOSE ONE):**	**VISION PLAN:**
☐ ANTHEM BLUE CROSS (PPO)	☐ NEVADA DENTAL PLAN (PPO)	☐ DAVIS VISION
☐ ANTHEM BLUE CROSS (EPO)	☐ MANAGED CARE DENTAL PLAN (HMO)	
RX PLAN:		
SAV-RX		

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

DEPENDENTS - (Including Spouse)

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

FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP

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:** _____

Mailing Address: P.O. Box 400700 ◆ Las Vegas, NV 89140
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