

**Southern Nevada Painters and Glaziers Trust Funds**

Glazing Health and Welfare Trust • Southern Nevada and California Glaziers, Fabricators, Painters and Floorcoverers Pension Trust Fund • Southern Nevada Painters, Decorators and Glaziers LMCC Trust

**ENROLLMENT FORM  
(GLAZIER)**

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

EMPLOYEE'S FULL NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ GENDER: (Check One) Male \_\_\_\_ Female \_\_\_\_

PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ EMAIL: \_\_\_\_\_

<b><u>MEDICAL &amp; RX PLAN:</u></b>  HEALTH PLAN OF NEVADA – POINT OF SERVICE PLAN	<b><u>DENTAL PLAN: (CHOOSE ONE)</u></b>  <input type="checkbox"/> LIBERTY DENTAL PLAN (HMO) <input type="checkbox"/> DELTA DENTAL (PPO)	<b><u>VISION PLAN:</u></b>  VISION SERVICE PLAN (VSP)
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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*

FULL NAME	SSN	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:** \_\_\_\_\_