CEMENT MASONS AND PLASTERERS LOCAL 797 BENEFIT FUNDS

8311 W. Sunset Road, Suite 250 • Las Vegas, NV 89113
P.O. Box 400008 • Las Vegas, NV 89140
Phone (702) 415-2190 • Fax (702) 257-5361

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: (________)________________EMAIL:______________________ GENDER: (Check One) Male ____ Female ____

MEDICAL PLAN:	**DENTAL PLAN (CHOOSE ONE):**
BEECHSTREET (PPO)	☐ DIVERSIFIED DENTAL (PPO) ☐ DELTA DENTAL (DHMO)
INCLUDED WITH YOUR PLAN VISION PLAN: VISION SERVICE PLAN (VSP) PRESCRIPTION PLAN: ENVISION 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

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

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. By signing this form, I also acknowledge that I have reviewed the enclosed *information* and understand that I must use providers (doctors, hospitals, etc.) that participate in the networks for the Plans I have chosen above. I understand that I may be responsible for payment of any and all expenses, including deductibles and co-pays that are not covered when I do not use a participating provider. I also understand that I may change my dental selection at any time during the year, once in any twelve (12) consecutive period, provided that I have been enrolled in the current dental selection for at least twelve (12) months.

PARTICIPANT SIGNATURE ________________________________ **DATE:** ____________________