2018
SAN DIEGO ELECTRICAL HEALTH AND WELFARE TRUST
ANNUAL PARTICIPANT INFORMATION UPDATE

PLEASE COMPLETE ALL INFORMATION ON THIS FORM.
THIS FORM MUST BE COMPLETED BEFORE ANY 2018 CLAIMS CAN BE PROCESSED

1. Participant's Full Name and Address:

____
Name

____
Street Address

____
City, ST Zip Code

☐ Male ☐ Female Last 4 SSN xxx-xx-__________

Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ Dom Part

Phone: (H)(_____)__________ Cell: (_____)__________

Email: ______________________________

2. Spouse/Domestic Partner Full Name: ______________________________

Is Spouse/Domestic Partner currently employed?: ☐ Yes ☐ No

Phone (H): (_____)__________ Cell: (_____)__________ Email: ______________________________

If currently employed, Spouse/Domestic Partner Employer's Name and Address:

____

3. Does the Participant, Spouse/Domestic partner or any other family member have group medical insurance **offered** through employment or any other source? ***ie: Medi-Cal, Medicare, School Insurance, Tricare etc.*** ☐ Yes ☐ No

If yes, is the **least expensive coverage** offered at a cost of **$100.00 or less** per month? ☐ Yes ☐ No

If group medical insurance coverage was offered, was it waived or declined? ☐ Yes ☐ No

Is he/she receiving any compensation from their employer or any other source for waiving or declining group medical insurance coverage? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

____

4. If there is **any other group medical insurance**, through employment or any other means, please provide insurance information and submit a copy of the identification card with this form.

______________ ______________ ______________
Name of Insured Insurance Co Address

______________ (_____)__________
Policy or Group Number Phone

Is group medical insurance coverage for your Spouse/Domestic partner only? ☐ Yes ☐ No

If no, please list all family members covered under the group medical insurance coverage:

______________________________ ______________________________

______________________________ ______________________________

CONTINUE ON BACK

5. Please list any and all dependent children enrolled and covered under the San Diego Electrical Health and Welfare PPO Plan, please include date of birth and employment information, if applicable.

NAME	DATE OF BIRTH	MARITAL STATUS	FULL ADDRESS IF DIFFERENT FROM YOURS	EMPLOYED? Y or N

Please be advised:

If a child is a stepchild, legally adopted child, foster child or under legal guardianship, the Trust Office must have sufficient documentation to verify this relationship to the Participant before coverage may be verified or any claim payment(s) may be made.

Any change in marital or dependent status must be reported to the Trust Office within 30 days after their coverage ends in order to possibly be eligible for a HIPAA Special Enrollment opportunity.

Note:

If at any time during the calendar year, other coverage for your spouse terminates, please provide a copy of the termination letter to the Trust Office within 30 days of the termination date.

6. I hereby certify under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

Participant's Signature: ______________________________ Date: ______________

7. **Electronic Notification Authorization:**

I authorize use of my email address and cell phone number to receive electronic notifications from the Trust. I authorize the Trust to use electronic notification to notify me regarding **general** Plan rules, changes, and reminders. I understand that electronic communication is not secure and that it may be intercepted by unauthorized persons. To that effect, no personal or protected health information will be communicated via electronic communication. I understand that this election will remain in place until I revoke this authorization by contacting the Trust Office with my request to be removed from the electronic notification system. Check all boxes for which you provide consent to receive electronic communication.

- ☐ E-mail
- ☐ Text
- ☐ I do not authorize use of Electronic Notification

Participant's Signature: ______________________________ Date: ______________