2019
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 2019 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: _____ Date of Birth: _____

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 no, skip to number 5.

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 for each person 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 on their behalf.

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: _____