IBEW LOCAL 569

SAN DIEGO ELECTRICAL HEALTH & WELFARE TRUST
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NECA
San Diego Chapter
National Electrical
Contractors Association Inc.

2024

PARTICIPANT INFORMATION & COORDINATION OF BENEFITS QUESTIONNAIRE

This form must be completed to notify the Trust Office of any Participant changes or for Medicare, Medi-Cal, or any other health insurance coverage for Coordination of Benefits (COB).

Please check the reason for submission:

☐ Annual Update ☐ Add other Insurance ☐ Termination of other insurance

☐ Add spouse/dependent ☐ New Enrollee

Employee Information (Union Member or Non-Bargaining Employee/Not Spouse or Dependents):

Name:_____ Last 4 SSN: _____

Street Address:_____ Marital Status:_____

City:_____ *Phone:_____

State:_____ ZIP:_____ *E-mail:_____

THE ABOVE BOX IS REQUIRED TO BE COMPLETED. (PLEASE PRINT)

☐ No changes in address, marital status, dependents, other insurance coverage, and spouse's employment.** Skip the rest of the form, sign page 2, and return to the Trust Office.

ARE YOU OR ANY OF YOUR COVERED DEPENDENTS ALSO COVERED BY ANOTHER GROUP HEALTH PLAN?

☐ NO - Complete the back side of the form, sign, and return.

☐ YES - Complete the entire form, sign, and return.

OTHER HEALTH COVERAGE:

☐ Yes - No changes from prior year. Information on file with Trust Office.

☐ Yes - Send copy of insurance card (front and back) to Trust Office with this form.

☐ No – Insurance terminated for Spouse/Dependent: _____

****SPOUSE EMPLOYMENT INFORMATION: (See Enclosed Spousal Exclusion Rule)**

If your Spouse is employed, please complete the following:

☐ Spouse has Employer coverage. (Send copy of front and back of insurance card)

☐ Single Coverage ☐ Family Coverage

☐ Spouse does not have coverage (complete questions below)

Is group medical insurance offered? ☐ No – Sign form and return
☐ Yes – answer questions below

Is the least expensive insurance coverage offered by their employer $100 or less. The coverage only has to be for the Spouse (does not need to be family coverage). ☐ Yes ☐ No

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

Is your Spouse receiving any compensation for waiving or declining coverage? ☐ Yes ☐ No

ADDITION OF SPOUSE OR DEPENDENTS:

Name	Date of Birth	Marital Status	Address (if different)	Employed? Y or N

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 communications.

☐ E-mail/Text (electronic only) ☐ Mail Only (paper only)

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:_____