Please print clearly:

SAN DIEGO ELECTRICAL HEALTH & WELFARE TRUST
GROUP HEALTH ENROLLMENT AND RECORD CARD

Participant's Last Name _____ First Name _____ MI _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip _____ Date of Birth ____/____/____

Sex: ❑ M ❑ F ❑ Other Email: _____ Phone (____) _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Domestic Partner

DEPENDENT INFORMATION
Please only list dependents whom you wish to enroll.

Spouse or Domestic Partner Required Documents: Original government-issued (a) marriage certificate or (b) domestic partnership certificate

❑ M ❑ F ❑ Other Name (first, middle, last): _____

Date of Birth: _____ Social Security Number: _____

Child(ren) Required Documents: Original government-issued birth certificate, court order guardianship, or final adoption order

❑ M ❑ F ❑ Other Name (first, middle, last): _____ Social Security Number: _____

Address (if different than Participant): _____ Date of Birth: _____

❑ M ❑ F ❑ Other Name (first, middle, last): _____ Social Security Number: _____

Address (if different than Participant): _____ Date of Birth: _____

❑ M ❑ F ❑ Other Name (first, middle, last): _____ Social Security Number: _____

Address (if different than Participant): _____ Date of Birth: _____

❑ M ❑ F ❑ Other Name (first, middle, last): _____ Social Security Number: _____

Address (if different than Participant): _____ Date of Birth: _____

Please complete reverse side

DESIGNATION OF BENEFICIARY FOR LIFE INSURANCE

Please Pay My Death Benefits to:

Last Name _____ First Name _____ MI _____ Social Security Number _____

Beneficiary's Street Address _____ City _____ State _____ Zip _____ Date of Birth ____/____/____

Relationship of Beneficiary to Participant _____

I acknowledge that this designation of beneficiary controls the payment of Life Insurance benefits provided by the San Diego Electrical Health & Welfare Trust, and that it is my responsibility to change this designation if, because of death, termination of marriage, or otherwise, I no longer want this person to be my beneficiary.

I declare under penalty of perjury that my spouse or Domestic Partner and each of my listed dependents meet all eligibility requirements of the San Diego Electrical Health and Welfare Trust. I acknowledge that except as expressly provided under the Plan my dependent children must be under the age of 26. It is further acknowledged that any change in marital status, domestic partnership or dependent status must be reported to the Trust Office within 60 days by filing a copy of a Judgement of Dissolution and completing a new Enrollment and Record Card.

I acknowledge that payment of any benefits which are excluded under the Plan are subject to the "Right of Recovery" in the Plan, except as otherwise provided under the terms of the plan.

Name of Participant (printed) _____

Signature of Participant _____ Date _____

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