



**SAN DIEGO ELECTRICAL HEALTH & WELFARE TRUST**  
**4545 VIEWRIDGE AVENUE, SUITE 110**  
**SAN DIEGO, CA 92123**  
**(858) 569-6322**  
**(800) 632-2569**



## 2026

### 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: \_\_\_\_\_

Mailing 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: \_\_\_\_\_

