



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



2027 UDPATE (ANTHEM BLUE CROSS PPO ONLY)

PARTICIPANT INFORMATION & COORDINATION OF BENEFITS QUESTIONNAIRE

Fill out this form to tell the Trust Office about any changes to the Participant or any Medicare, Medi-Cal, or other health insurance. The Trust Office uses this information to coordinate benefits (COB).

Check one reason for sending this form:

- ☐ New Enrollee ☐ Add spouse/dependent ☐ Add other Insurance
- ☐ Annual Update ☐ Termination of other insurance

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 BOX ABOVE MUST BE FILLED OUT. PLEASE PRINT.

☐ Nothing has changed with my address, marriage status, dependents, other insurance, or spouse's job. If you check this box, skip the rest of the form. Sign page 2 and return the form to the Trust Office.

DO YOU OR ANY COVERED DEPENDENT HAVE ANOTHER GROUP HEALTH PLAN?

- ☐ NO — Fill out the back of the form. Please sign and return it.
- ☐ YES — Fill out the whole form - Front & Back. Then please sign and return it.

OTHER HEALTH COVERAGE: (A Termination Letter is required if No is selected below)**

- ☐ Yes — Nothing changed since last year. The Trust Office already has the information.
- ☐ Yes — Send a copy of the front and back of the insurance card with this form to the Trust Office.
- ☐ **No — Coverage terminated during the year on: ____ / ____ / ____ (effective termination date)

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

If your spouse has a job, answer the questions below:

☐ My Spouse has insurance from an employer. Send a copy of the front and back of the insurance card.
Is the employer insurance coverage: ☐ **Single Coverage** ☐ **Family Coverage**

☐ My spouse does not have insurance. Answer the questions below.

1. Does the employer offer group medical insurance? ☐ **No** — Sign and return the form.
☐ **Yes** — Answer the questions below
2. Does the employer offer a health insurance plan for your spouse that costs \$100 or less per month? (The plan does not have to be the one that they choose. Plus, the plan only needs to cover the spouse, not the entire family.) ☐ **Yes** ☐ **No**
3. If the employer offered group medical insurance, did your spouse decline it? ☐ **Yes** ☐ **No**
4. Does your spouse get any incentive/payment for not accepting the insurance? ☐ **Yes** ☐ **No**

ADDITION OF SPOUSE OR DEPENDENTS:

Name	Date of Birth	Marital Status	Address (if different) * Required for Adult Children 18+	*Phone #	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 people. 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

☐ 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:** _____