

# SHOP IRONWORKERS LOCAL 790 WELFARE PLAN ENROLLMENT FORM – ACTIVE

556 South Fair Oaks Avenue #30, Pasadena CA 91101  
(866) 339-7467 • (626) 792-7335 Fax

**PLEASE FILL OUT THE FORM COMPLETELY AND LEGIBLY**

**I AM A**

NEW MEMBER

**OR, I AM CHANGING MY**

NAME

ADDRESS

DEPENDENTS\*

MARITAL STATUS

BENEFICIARY

DENTAL COVERAGE

PARTICIPANT DATA										
LAST NAME			FIRST NAME			INIT.	SOCIAL SECURITY NUMBER			
MAILING ADDRESS (STREET OR P.O. BOX)						SEX (M/F)		DATE OF BIRTH		
CITY			STATE		ZIP	TELEPHONE NUMBER (     )				
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED			DATE OF MARRIAGE/DIVORCE		EMPLOYER			DATE OF HIRE		
					<input type="checkbox"/> BARGAINED <input type="checkbox"/> NON-BARGAINED					
<b>MEDICAL SELECTION –</b>  <input type="checkbox"/> BLUE CROSS PRUDENT BUYER (EFF 8/1/07)					<b>CHOICE OF PLANS DENTAL SELECTION – CHOOSE ONE:</b>  <input type="checkbox"/> CIGNA DENTAL PPO- GRP #3337027 <input type="checkbox"/> PACIFIC UNION DENTAL - GRP #95566 <input type="checkbox"/> CIGNA DENTAL DHMO - GRP #3337027					
FAMILY DATA										
FULL NAME		RELATION**		SEX	DATE OF BIRTH		SOCIAL SECURITY #			
SPOUSE										
DEPENDENT										
DEPENDENT										
DEPENDENT										
DEPENDENT										
**Relation – Spouse, Son, Daughter, Stepson, Stepdaughter, Other										

Important Notice: I apply for Health Plan membership for the persons listed and agree that we shall abide by the provisions of the Health Maintenance Organization (HMO) service agreement or preferred provider plan regulations, whichever applies. I understand that the service agreement provides that all claims, including medical malpractice claims, which arise because I or someone with a relationship to me, believed that some conduct in, or arising from my relationship with the HMO, HMO hospitals, or the HMO medical group, as a member or as a patient, has caused any harm, must be submitted to binding arbitration instead of court trial.

THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT SELECTION(S)

DATE: \_\_\_\_\_

SIGNATURE \_\_\_\_\_

(OVER)

**INSTRUCTIONS:** (Please read carefully before completing the "Enrollment Form")

The Enrollment Form must be completed in order to enroll you and your dependents, if applicable, for Health & Welfare coverage under one of the Fund's Plans. Be sure to complete all of the information requested on the Enrollment Form. Under the terms of your coverage, you may make an election of the Medical and Dental Plan. Be sure to complete the box marked "CHOICE OF PLANS".

Please read your Summary Plan Description for descriptions of the various plans.

**TO ADD OR CHANGE YOUR DEPENDENT, THE FOLLOWING DOCUMENTATION IS REQUIRED.**

- COPIES OF CERTIFIED MARRIAGE CERTIFICATE OR DIVORCE PAPERS
- COPIES OF CERTIFIED BIRTH CERTIFICATES FOR DEPENDENT CHILDREN
- FOSTER & ADOPTED CHILDREN: LEGAL GUARDIANSHIP OR COURT ADOPTION PAPERS

**DEPENDENT ELIGIBILITY AND ENROLLMENT – WHO IS ELIGIBLE:**

**If YOU qualify for benefits, the following dependents may be covered:**

- **YOUR LEGAL SPOUSE**
- Children who are less than 26 years of age. Eligible dependent children include your:
  - NATURAL CHILDREN
  - STEP-CHILDREN
  - LEGALLY ADOPTED CHILDREN
  - CHILDREN PLACED FOR ADOPTION
  - CHILDREN FOR WHOM YOU HAVE BEEN LEGALLY APPOINTED GUARDIAN.
- **\*DEPENDENTS WHO ARE OFFERED COVERAGE BY HIS/HER EMPLOYER BUT DENIES THAT COVERAGE WILL NOT BE ELIGIBLE (INCLUDING COVERAGE THROUGH THEIR SPOUSES EMPLOYER).**
- **DISABLED DEPENDENT CHILDREN** over age 19 and incapable of self-supporting employment because of mental retardation or physical handicap will have eligibility extended.

**ELIGIBILITY FOR ALL PERSONS LISTED ABOVE SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE TRUST AGREEMENT AND PLAN DOCUMENT AS WELL AS TO ANY RULES OR REGULATIONS ADOPTED BY THE BOARD OF TRUSTEES.**

The Enrollment Form requires that you name a beneficiary to your *Death and Accidental Death & Dismemberment Benefits* under the Fund. Be sure to complete it and be specific as to which you are naming – give full name with Jr., Sr., etc., to avoid confusion with anyone else.

<b>BENEFICIARY OF DEATH BENEFIT</b>			
BENEFICIARY'S FULL NAME & ADDRESS	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY #
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BENEFICIARY'S FULL NAME & ADDRESS	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY #

\_\_\_\_\_  
YOUR SIGNATURE

\_\_\_\_\_  
DATE

**Please submit your marriage certificate if married  
and/or birth certificates for any dependents you are enrolling**