

**SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST**  
720 Market Street, Suite 700, San Francisco, CA 94102  
(415) 263-3670

**PLAN CHANGE REQUEST FORM**

I have read the enclosed Comparison of Benefits and would like to change to the following Plan. (Please check the appropriate box, fill in the information requested below and return this form and the information, along with the appropriate enrollment form and/or identification card, will be sent to you.)

- SELF-FUNDED PPO (AVAILABLE WORLD WIDE)
- KAISER (CALIFORNIA ONLY- must reside within a 30 mile radius of a Kaiser facility)
- BLUE SHIELD (Limited to certain geographic areas in California Only- contact Plan Office for more information or the Blue Shield website @ [www.blueshieldca.com](http://www.blueshieldca.com)).

If you have had a change in dependent status or wish to change your beneficiary designation, please check the appropriate box.

- CHANGE IN BENEFICIARY STATUS
- CHANGE IN DEPENDENT STATUS

\_\_\_\_\_  
Your Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code