DOCUMENTS REQUIRED FOR ENROLLMENT

Please provide copies of any applicable documentation as outlined below.

ENROLLING THE PARTICIPANT:

- ❑ Complete Section 1 on the Enrollment Form.

ENROLLING SPOUSE:

- ❑ Complete Section 2 on the Enrollment Form.
- ❑ Marriage Certificate

ENROLLING REGISTERED DOMESTIC PARTNER

- ❑ Complete Section 2 on the Enrollment Form
- ❑ State or County Registration of Domestic Partnership
- ❑ Complete Declaration of Domestic Partnership
- ❑ If Partner is claimed as a Dependent for Income Tax Purposes, Complete Affidavit of Dependency For Tax Purposes
- ❑ If Partner is not claimed as a Dependent for Income Tax Purposes, advance payment of required payroll taxes. (Plan Office will provide this information upon receipt of completed Declaration of Domestic Partnership.)

ENROLLING ONE OR MORE CHILDREN THROUGH AGE 18

- ❑ Complete Section 3 on the Enrollment Form and include copies of any applicable documents below.

Natural Child

- ❑ Birth Certificate of Child

Dependent Child from Previous Marriage

- ❑ Birth Certificate of Child
- ❑ Divorce Decree & Settlement of prior marriage

Step Child or Child of Domestic Partner

- ❑ Birth Certificate of Child
- ❑ Name of other legal parent, including information regarding any other insurance coverage.

Child for Which Participant is Guardian

- ❑ Birth Certificate of Child
- ❑ Guardianship/Custody documents

Adopted Child

- ❑ Birth Certificate of Child
- ❑ Final Adoption Order or copy of Placement Agreement if the adoption is not yet final.

Child Born Outside of Marriage

- ❑ Birth Certificate of Child
- ❑ Court Order Regarding Insurance (Qualified Medical Child Support Order "QMSCO")
- ❑ Name of other legal parent, including information regarding any other insurance coverage.

ENROLLING ONE OR MORE CHILDREN AGE 19 THROUGH AGE 25

- ❑ Complete Section 4 on the Enrollment Form
- ❑ Birth Certificate of Child

Important Note: If you have a family member who qualifies as a Dependent under the Plan, you may enroll your Dependent in the Plan only: (i) when you first enroll for coverage, (ii) during open enrollment periods (which usually occur during the month of July with changes effective August 1), or (iii) within 30 days of when the family member first becomes a dependent. If your coverage lapses during open enrollment and you re-establish your eligibility, you may enroll your Dependents within 30 days of the date you re-established your eligibility under the Plan. All of your Dependents are covered by the same option that covers you, if they are properly enrolled in the Plan. No benefits are payable for any person who is not properly enrolled (except that the Plan's Special Enrollment Provision may allow delayed enrollment under limited circumstances).

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
720 MARKET ST., STE. 700
SAN FRANCISCO, CA 94102
Ph. (415) 263-3670 Fx. (415) 263-3672

SECTION 1: PARTICIPANT ENROLLMENT INFORMATION

Check One: ☐ Initial Enrollment ☐ Change in Enrollment Status

Soc. Sec. No.		Birth Date			
Last Name		First Name		M. Inl.	
Address					
City		State		Zip Code	
Phone Number		E-Mail Address			
Marital Status	☐ Single ☐ Married ☐ Registered Dom. Partner ☐ Widowed ☐ Divorced	Gender	☐ Female ☐ Male		
Plan Selection*	☐ Self Funded PPO ☐ Kaiser ☐ Blue Shield HMO				

*Note: If this is not an initial enrollment, no change in plan selection may be made until the Plan's Open Enrollment Period.

SECTION 2: SPOUSE/DOMESTIC PARTNER** ENROLLMENT INFORMATION
(Complete If Your are Married or have a Registered Domestic Partnership)

Soc. Sec. No.		Birth Date			
Last Name		First Name		M. Inl.	
Spouse's Employer		Phone			

Is medical coverage available through your spouse's employment? ☐ Yes ☐ No ☐ Unemployed
If yes, did your spouse elect to be covered under her employer's plan? ☐ Yes ☐ No
If yes, provide information below.

Name of Insurance		Effective Date	
Address		Phone	

Does your Spouse/Partner's insurance provide coverage for dependent children? ☐ Yes ☐ No
If Yes, is coverage provided for Adult Child(ren) listed in Section 4? ☐ Yes ☐ No

**Note: Domestic Partner Coverage may be considered imputed income for Federal and/or State taxes purposes, and be subject to advance payment of Federal and/or State Payroll taxes as a condition of enrollment.

SECTION 3: UNDER AGE 19 CHILD ENROLLMENT INFORMATION
(If applicable, list Adult Children Age 19 through Age 25 in Section 4 on the Back Page)

Soc. Sec. No.	Last Name, First Name	Birth Date	Gender	Relationship***

***1) Natural Child; 2) Step Child; 3) Adopted Child; 4) Child of Domestic Partner; 5) Child by Legal Guardianship

I certify the accuracy of the above information and understand that I must inform the Plan Office of any changes

Participant's Signature	Date Signed

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An Adult Child age 19 through 25 may be eligible for coverage on the same basis as dependent children under the Plan.

SECTION 4: ADULT CHILD (Age 19 through Age 25) ENROLLMENT INFORMATION						
Adult Child		Birth Date		Soc. Sec. No.		
Adult Child Address						
Is this adult child employed? ☐ Yes ☐ No	If Yes, Provide Name and Address of Employer:					
Does this adult child have medical insurance available (even if not elected) through his/her employment? ☐ Yes ☐ No	If Yes: Name/Address of Insurance					
	Phone No.		Policy No.		Effective Date	
Is other Medical Insurance available through a Parent other than the above named Participant? ☐ Yes ☐ No	If Yes: Parent's Name				Soc. Sec. No.	
	Name/Address of Insurance					
	Phone No.		Policy No.		Effective Date	
Is other Medical Insurance available (even if not elected) through the spouse of the Adult Child? ☐ Yes ☐ No ☐ Not Married	If Yes: Spouse's Name				Soc. Sec. No.	
	Name/Address of Insurance					
	Phone No.		Policy No.		Effective Date	

(A Separate Form Must Be Completed For Each Adult Child Enrollment Request)

PARTICIPANT CERTIFICATION REQUIRED TO REQUEST COVERAGE		
I certify the accuracy of the above information and choose to elect coverage on the indicated Adult Child. I understand that I must inform the Plan Office of any changes in Adult Dependent Status. In understand that I will be responsible for any overpayments that occur if a status change occurs and the Plan Office is not notified.		
Participant Name (Print):	Date:	Phone:
Participant Signature:		Participant SSN: