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

PLAN and DEPENDENT 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 HMO (Limited to certain geographic areas in California Only- contact Plan Office for more information or the Blue Shield website @ www.blueshieldca.com).

If you 1) have had a change in dependent status, 2) elect to add an adult child ages 19 through 25 or 3) wish to change your beneficiary designation, please check the applicable box below:

- ☐ CHANGE IN BENEFICIARY STATUS
- ☐ CHANGE IN DEPENDENT STATUS
- ☐ ADD ADULT CHILD AGES 19 THROUGH 25

_____
Your Name (please print)

_____
Signature

_____
Social Security Number

_____
Street Address

_____
City, State, Zip Code