OFFICE & PROFESSIONAL EMPLOYEES LOCALS 30 & 537 HEALTH & WELFARE FUND
13191 Crossroads Parkway North Suite 205 City of Industry, CA 91746-3434 Telephone (800) 386-4350 (562) 463-5065 Fax (562) 908-7568

OFFICE USE ONLY: Coverage Effective: _____

ENROLLMENT FORM

- Indicate Coverage Selected:
- □ **Major Medical Plan/PPO Plan**
- □ **Basic Dental Coverage**
- □ **Vision Coverage**

- Decline Coverage:
- □ **Dental Coverage**
- □ **Vision Coverage**

- □ **DEPENDENT ADDITION**
- □ **DEPENDENT DELETION**
- □ **NAME CHANGE**

In accordance with Health Care Reform regulations, you have the option to decline the Plan's dental and vision coverage. Note that there is no additional compensation to you if you choose to decline/waive dental and/or vision coverage. If you decline dental and/or vision coverage you may re-enroll for such coverage during the Fund's next open enrollment period scheduled for January 2016.

LIST LEGAL DEPENDENTS YOU WISH TO ENROLL

NOTE: Submit copies of appropriate legal documents (marriage certificate, birth certificate, etc.) to verify dependents' eligibility.

	LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER (Required)	BIRTH DATE (Required)	OTHER MEDICAL COVERAGE?	Medicare ?	Part A	Part B	Part C
Self □Male □Female						□ Yes □No	□Yes □No Eff.	□Yes □No	□Yes □No	□Yes □No
Spouse □Male □Female						□ Yes □No	□Yes □No Eff.	□Yes □No	□Yes □No	□Yes □No
□Son □Daughter						□ Yes □No	□Yes □No Eff.	□Yes □No	□Yes □No	□Yes □No
□Son □Daughter						□ Yes □No	□Yes □No Eff.	□Yes □No	□Yes □No	□Yes □No
□Son □Daughter						□ Yes □No	□Yes □No Eff.	□Yes □No	□Yes □No	□Yes □No

MEMBER'S ADDRESS: _____ **PHONE NO.** _____

_____

Present Employer (Company Name): _____ **Position:** _____

SIGNATURE: _____ **DATE:** _____

RETURN COMPLETED FORM TO THE ABOVE ADDRESS WITHIN 30 DAYS