

**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  
EFFECTIVE DATE OF COVERAGE: \_\_\_\_\_

**ENROLLMENT FORM**

Indicate Coverage Selected:

- Major Medical Plan/PPO Plan
- Basic Dental Coverage

- NEW ENROLLMENT
- DEPENDENT ADDITION
- DEPENDENT DELETION
- NAME CHANGE

**LIST LEGAL DEPENDENTS YOU WISH TO ENROLL**

**NOTE: Children between the ages of 19 and 25 must have student certification on file with the Administrative Office to be eligible for benefits. Submit copies of appropriate legal documents (marriage certificate, birth certificate, etc.) to verify dependents' eligibility.**

	LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER (Required for Major Medical Enrollment)	BIRTH DATE	OTHER MEDICAL COVERAGE?	Medicare ?	Part A	Part B	Part C
Self						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Eff.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Eff.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Eff.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Eff.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Eff.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEMBER'S ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE NO. \_\_\_\_\_

Present Employer (Company Name): \_\_\_\_\_ Position: \_\_\_\_\_

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

**RETURN COMPLETED FORM TO THE ABOVE ADDRESS WITHIN 30 DAYS**