OFFICE & PROFESSIONAL EMPLOYEES LOCALS 30 & 537 HEALTH & WELFARE FUND

1200 Wilshire Boulevard, Fifth Floor, Los Angeles, CA 90017-1906 Telephone (800) 386-4350 (562) 463-5065 Fax (562) 463-5894

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 open enrollment period held in January of each year.

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