SEIU HEALTH & WELFARE FUND ENROLLMENT/WAIVER FORM

Please Print Clearly

FIRST NAME: _____ LAST NAME: _____

SSN: ____ ____ ____ - ____ ____ - ____ ____ ____ ____ DATE **OF BIRTH:** _____ /_____ / _____ **SEX**: MALE FEMALE

HOME STREET ADDRESS/APT #: _____

CITY: _____ **STATE: _____ZIP CODE: _____**

NAME OF EMPLOYER: _____

EMPLOYEE NUMBER: _____ **DATE OF HIRE**: _____

Children for enrollment – Eligible children include child by birth or legal adoption that are age 26 or younger.

FIRST NAME	LAST NAME	DOB	SSN	RELATIONSHIP (Circle one)
				Son Daughter
				Son Daughter
				Son Daughter
				Son Daughter

CHOOSE ENROLLMENT OPTION:

□ I **DO NOT** want to enroll in the health insurance plan. I understand that I am waiving this coverage and that I will not be able to enroll until the next open enrollment period or unless I have a qualifying event.

□ I want to enroll in the health insurance plan for **MYSELF ONLY**. I authorize my employer to process my payroll deduction (according to the CBA between my employer and the SEIU local 26). I understand that I cannot drop coverage until the next open enrollment period or unless I have a qualifying event.

□ I want to enroll in the health insurance plan for **MYSELF AND MY ELIGIBLE CHILDREN** listed above. I authorize my employer to process my payroll deduction (according to the CBA between my employer and the SEIU local 26). I understand that I cannot drop coverage until the next open enrollment period or unless I have a qualifying event.

_____ _____

Signature **Date**

By signing this form, I attest that all information provided is true and correct