ENROLLMENT FORM

RIVERSIDE COUNTY ELECTRICAL HEALTH & WELFARE TRUST FUND

2831 Camino del Rio S. #311
San Diego, CA 92108
(800) 736-0401

COMPLETE ALL INFORMATION–PLEASE PRINT IN INK. THE PURPOSE OF THIS FORM IS TO ENSURE THAT YOU AND YOUR ELIGIBLE DEPENDENTS CAN PARTICIPATE IN THE RIVERSIDE COUNTY ELECTRICAL HEALTH & WELFARE PLAN, AND INCLUDES ENROLLMENT IN THE INDEMNITY MEDICAL PLAN. **IF YOU WISH TO ENROLL IN AN HMO, YOU MUST ALSO COMPLETE AN APPLICATION FOR THAT HMO**. PLEASE CONTACT THE ADMINISTRATION OFFICE FOR DETAILS.

PARTICIPANT DATA

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

MAILING ADDRESS (STREET OR P.O. BOX)	SEX	DATE OF BIRTH		

CITY	STATE/ZIP	TELEPHONE NUMBER	EMAIL ADDRESS
		( )	

DEPENDENT DATA (FOR INFORMATION ON DEPENDENT ELIGIBILITY, PLEASE SEE OTHER SIDE.)

DEPENDENT'S NAME	RELATIONSHIP TO PARTICIPANT*	SEX	DATE OF BIRTH			SOCIAL SECURITY NUMBER

*Relationship: Spouse, Child, Stepchild, Other (see other side for definition of eligible dependents).

LIFE INSURANCE

Primary Beneficiary	NAME		RELATIONSHIP
ADDRESS		TELEPHONE NUMBER	EMAIL ADDRESS
Secondary Beneficiary	NAME		RELATIONSHIP
ADDRESS		TELEPHONE NUMBER	EMAIL ADDRESS

I HEREBY DECLARE THAT ALL STATEMENTS AND ANSWERS ABOVE ARE TRUE, AND THAT THEY ARE THE BASIS ON WHICH COVERAGE MAY BE EXTENDED UNDER THE PLAN.

Employee Signature ______________________ Date ______________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and/or disclosure of all individually identifiable health information by the Welfare Fund and the Plan Administrator. By signing below, I indicate that I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive information is not a health plan or health care provider, the released information may be re-disclosed and may no longer be protected by federal privacy regulations. Additionally, the following person/organization is authorized to receive private health information on my behalf:

Name ____ Relationship ____________________________

I understand that I may establish an expiration date or revoke this authorization at any time by providing written notice to the Privacy Officer for the Trust Fund. I may refuse to sign this authorization and my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or eligibility for benefits.

Employee Signature ____ Date ________________________________

DEPENDENTS ELIGIBILITY

Only the following are eligible for dependents insurance:

- Your lawful spouse;
- Your natural-born child or your adopted child or child placed with you from moment of placement during adoption proceeding up to age 26, provided that he/she is not eligible for other employment-based coverage;
- Your stepchild up to age 26, provided that he/she is not eligible for other employment-based coverage;
- A foster child up to age 26, provided that he/she is not eligible for other employment-based coverage.

A mentally retarded or physically handicapped child who has reached the age of 26 while insured under the policy may be continued if the child:

1. Is chiefly dependent on you for support; and
2. Is not capable of self-sustaining employment; and
3. You give us proof of the child's handicap:
    1. Not later than 31 days after the child attains the limiting age; and
    2. Thereafter as the Trustees may require, but not more than once every two years.

Dependent eligibility begins on the later of the day you become insured under the Plan, or the day you first acquire an eligible dependent provided that you notify the Administration Office.

TO ADD OR CHANGE A DEPENDENT, THE FOLLOWING DOCUMENTATION MAY BE REQUIRED:

- For addition or deletion of coverage: copy of the original marriage certificate or divorce papers, as applicable.
- For addition of a natural-born child: copy of the original birth certificate.
- For foster and adopted children: legal guardianship or court adoption papers.

Eligibility for all persons listed on the prior page are subject to all provisions and limitation of the Trust Agreement and Plan Document (as amended) as well as to any rules or regulations adopted by the Board of Trustees. No coverage is provided for a dependent while that dependent is in full-time military service.