EMPLOYEE CHANGE FORM

MULTI UNION SECURITY TRUST FUND

EMPLOYEE INFORMATION

EMPLOYER NAME	UNIT NO	EFFECTIVE DATE

SOCIAL SECURITY NO	LAST NAME	FIRST NAME	MI

EMPLOYEE HOME ADDRESS	CITY	STATE	ZIP	EMPLOYEE HOME PHONE NO

DATE OF BIRTH	SEX	MARRIED	DATE OF HIRE	UNION ❑ Yes ❑ No	UNION LOCAL

Primary Care Physician	**Existing Patient (Y/N)**	**Provider Number**

TYPE OF CHANGE

❑ **Add Dependent(s)** ❑ **Address** ❑ **Beneficiary** ❑ **Other:**

COVERAGES

☒ **ANTHEM BLUE CROSS** ☒ **DENTAL HEALTH SERVICES** ☒ **DAVIS VISION**

DEPENDENT ENROLLMENT

List all dependents to be covered; dependent verification documentation is required for all dependents.

Provide the Social Security Number of each dependent you enroll. Federal regulations require health plans to report the names and Social Security Numbers of every covered individual to the IRS. If you do not select a provider (physician or doctor's office / dentist or dental office), one will be automatically assigned to you. You may change your provider, at a later date, by contacting the medical / dental carrier directly.

SPOUSE

First Name	MI	Last Name	Date of Birth	Sex	**Social Security No**

Primary Care Physician	**Existing Patient (Y/N)**	**Provider Number**

CHILD

First Name	MI	Last Name	Date of Birth	Sex	**Social Security No**

Primary Care Physician	**Existing Patient (Y/N)**	**Provider Number**

CHILD

First Name	MI	Last Name	Date of Birth	Sex	**Social Security No**

Primary Care Physician	**Existing Patient (Y/N)**	**Provider Number**

CHILD

First Name	MI	Last Name	Date of Birth	Sex	**Social Security No**

Primary Care Physician	**Existing Patient (Y/N)**	**Provider Number**

LIFE INSURANCE BENEFICIARY DESIGNATION

The benefits payable under the Trust Fund will be paid to your beneficiary or beneficiaries according to this designation or in the order of preference rules established by the Trust. Refer to your summary plan description for these preference rules. PRINT carefully the full Name and Relationship. If you wish beneficiaries to share benefits, designate the percentage or dollar amount of benefit you wish each to receive. The percentage given must equal 100% of the total amount of the benefit.

LIFE AMOUNT: $50,000

Beneficiary:	Relationship:	Percentage:
Beneficiary:	Relationship:	Percentage:

I UNDERSTAND THAT THESE CHANGES CANCEL ALL PREVIOUS BENEFICIARY DESIGNATIONS

AUTHORIZATION, ACKNOWLEDGEMENT AND DISCLOSURE OF PERSONAL INFORMATION

The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, section 56 et seq. of the California Civil Code. Your cooperation is requested.

Authorization to obtain or release medical information: I hereby authorize my physician, healthcare practitioners, hospital, clinic or other medically related facility to furnish to the Health Plan selected above, or its representatives or designee, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal (including the release to an independent review organization) or grievance, or for preventative health or health management purposes.

I authorize the Health Plan selected above, or its representative or designee, to disclose to the hospital or healthcare service plan, self-insurer, any such medical information obtained in such disclosure if necessary to allow the processing of any claim.

Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and the Health Plan selected above, any affiliated companies, or any Participating Physician Group/Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

Signature of Employee____ **Date**____________________