## **Benefits Change Form**

Phone number: 877-421-0177 Fax: 805-653-2032

Email: enrollment@seiu2015benefits.org Website: www.seiu2015benefits.org



Please print clearly when completing this form and return it to SEIU Local 2015 Benefit Center at the following address: P.O. Box 1788, Ventura, CA 93002

**Request Effective Date:** If your request is processed before the 15th of the current month, your change will be effective 1st of the following month. If your request is processed after the 15th of the current month, your request will be effective 1st of the month following 30 days due to payroll deduction timing requirements.

Name (First, Middle, Last)	9-digit Provider ID	County of Employment	
Phone No. (include area code)	Social Security Number		

ENROLLMENT CHANGES						
Add new dependents to: (Check all benefits you wish to add dependents)						
Vision	Life	Acciden	t			
DPP	t DPPO Coinsurance					
\$20,000	\$25,000	\$30,000 \$40,000	0			
	Il benefits you wish to Vision DPP	Il benefits you wish to add dependents)  Vision  Life  DPPO Scheduled Reimbursemen	Vision Life Acciden  DPPO Scheduled Reimbursement DPPO Coinsurance			

## **NEW DEPENDENT CHANGES**

Please list NEW dependents below: New dependents enrolling on the HMO dental need to choose a dentist in the MetLife network (facility number). *Failure to select an in-network dentist may result in delays in receiving dental benefits.* A full listing of dentists can be found at www.seiu2015benefits.org under MetLife Find a Provider.

Name (First, Middle, Last)  Spouse/Domestic Partner:	Date of Birth (MM/DD/YYYY)	Gender (M/F)	Dental	Vision	Life	Accident	DHMO Dental Facility ID Number
					\$5,000 \$10,000		
Child(ren):							
					\$1,000 \$2,000		
					\$1,000 \$2,000		
					\$1,000 \$2,000		

CANCELED DEPENDENT CHANGES						
Please list CANCELED dependents below and indicate the plans you wish to cancel dependent coverage.						
Name (First, Middle, Last)	Date of Birth	Gender	Dontal	Vision	Lifo	Accident
Spouse/Domestic Partner:	(MM/DD/YYYY)	(M/F)	Dental	VISIOII	LIIE	Accident
Child(ren):						

BENEFITS CANCELLATION					
Cancel coverage for me: (Check all benefits you wish to cancel)					
Dental	Vision	Life	Accident	Legal	
Reason for cancellation:					
Unhappy with benefits No longer working		No longer a union member Enrolled in other coverage	Do not want t	to pay premiums	

## PLAN LIMITATIONS

There are plan limitations that limit eligibility for the Dental, Vision, Life/AD&D, Accident, and Legal Plans. Please review the following limitations:

• Child coverage for all plans terminates at age 26, unless mentally or physically disabled. (Proof of disability required)

<u>LIFE/AD&D</u>: Member must be enrolled in Life/AD&D insurance in order to add dependent coverage.

**ACCIDENT**: Member and spouse must be under the age of 65 to enroll in Accident coverage.

## **DECLARATION SECTION**

Each person signing below **declares** that all the information given in this enrollment form is true and completed to the best of his/her knowledge and belief. Each person understands that this information will be used to determine his or her eligibility.

**For Payroll Deduction Authorization by the Member.** I authorize SEIU Local 2015 to initiate deductions from my pay for the coverage requested in this benefits change form. This authorization applies to such coverage until I rescind it in writing.

**Authorization to Release Dental Records.** I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all, dental records which pertain to me or any member of my family, maintained by my chosen Selected General Dentist and/or Specialty Care Dentist, to the dental insurance and/or any designated agent or representative for the purposes of dental treatment, care and for the dental insurance quality assessment and utilization reviews, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

Fraud Warning. Any person who knowingly and with intent to defraud any insurance company or other person files an application for benefits or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

You and your dependents may be eligible to continue your group health coverage through SEIU Local 2015 Long Term Care Workers Health Trust Fund following the occurrence of certain qualifying events under COBRA. For more information on your COBRA rights, please contact the SEIU Local 2015 Benefits Center at (877) 421-0177 to request a copy.

Signature: The Member must sign in all cases. The person signing below acknowledges that he or she has read and understands the statements and declarations made in this benefits change form.

Member Signature	Print Name	Date (Month / Day / Year)

<sup>\*</sup>Once enrolled you must stay enrolled in the dental, vision, life, and accident plans for a minimum of six (6) months. You must stay enrolled in the legal plan for a minimum of twelve (12) months.