Benefits Enrollment Form

Phone number: 877-421-0177 Fax: 805-653-2032
Email: enrollment@seiu2015benefits.org Website: www.seiu2015benefits.org

seiu 2015
California's Long Term Caregivers

Eligibility: SEIU Local 2015 dues-paying Member with a signed union card on file and in good standing.

Please print clearly when completing this form and return it to SEIU Local 2015 Benefits Center **(P.O. BOX 1788 Ventura, CA 93002)** Please note: All information is REQUIRED to process enrollment.

If your request is processed before the 15th of the current month, your change will be effective the 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.

STEP ONE: Member Information

Name (First, Middle, Last)	9-digit Provider ID		County of Employment
Address	City	Zip Code	Date of Birth (MM/DD/YYYY)
Social Security Number (Member's SSN is REQUIRED to complete the application)			Gender (M/F)
E-mail Address	Phone No. (include area code)		Primary Language

☐ I consent to receive plan and benefit information electronically at the email address provided above

STEP TWO: What benefits would you like to enroll in?

MetLife Dental HMO

☐ Member Only: $19.54/month ☐ Member Plus 1: $37.12/month ☐ Member Plus 2 or more: $51.79/month

When selecting the DHMO dental plan, you must select a dentist in the MetLife network. 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".

DHMO Dentist Choice (Name & Dental Facility ID number) ______________________________

MetLife Dental PPO Scheduled Reimbursement

☐ Member Only: $35.86/month ☐ Member Plus 1: $68.12/month ☐ Member Plus 2 or More: $95.02/month

MetLife Dental PPO Coinsurance

☐ Member Only: $53.28/month ☐ Member Plus 1: $101.66/month ☐ Member Plus 2 or More: $142.00/month

MetLife PPO Vision

☐ Member Only: $6.13/month ☐ Member Plus 1: $11.67/month ☐ Member Plus 2 or More: $18.42/month

Anthem Member Life/AD&D

☐ $5,000: $3.80/month ☐ $10,000: $5.30/month ☐ $20,000: $9.00/month
☐ $25,000: $10.90/month ☐ $30,000: $11.75/month ☐ $40,000: $15.40/month

Anthem Dependent Life/AD&D

☐ Spouse - $5,000: $3.75/month ☐ Child(ren) - $1,000: $1.25/month
☐ Spouse - $10,000: $6.75/month ☐ Child(ren) - $2,000: $2.25/month

**** Member must be enrolled in Life/AD&D coverage in order to enroll your Spouse and/or Child(ren).***

MetLife Accident

☐ Member Only: $9.47/month ☐ Member Plus Spouse: $17.22/month ☐ Member Plus Child(ren): $20.18/month
☐ Family: $23.45/month

****Member and spouse must be under the age of 65 to enroll.***

***ONCE ENROLLED YOU MUST STAY ON THE PLAN FOR A MINIMUM OF SIX (6) MONTHS**

STEP THREE: Dependent Information

To enroll your dependent in Dental, Vision, Life/AD&D, and Accident coverage, please check the plan(s) you wish to enroll your dependents in (please ONLY list dependents electing coverage):

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

Note: According to the plan rules, children are eligible for coverage through their 26th birthday, unless the dependent child has a mental or physical disability (Proof of disability required)

STEP FOUR: Life/AD&D and Accident Beneficiary Designation

Please specify your insurance beneficiaries below. Beneficiary allocation should equal 100%

Beneficiary	Relationship	Allocation %
Beneficiary	Relationship	Allocation %
Beneficiary/Contingent	Relationship	Allocation %

COBRA
You and your dependents may be eligible to continue your group health coverage through the 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.

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

For Changes Requested After Initial Enrollment Period Expires. I understand that if a benefit is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

For Payroll Deduction Authorization by the Member. I authorize SEIU Local 2015 to deduct from my pay the amounts for the coverage requested in this enrollment form in Step 2. I also authorize SEIU Local 2015 to deduct increases, if any, in the cost in future years. This authorization stays in effect for a minimum of 6 months and thereafter until I rescind 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 SafeGuard/MetLife and/or any designated agent or representative for the purposes of dental treatment, care and for SafeGuard's/MetLife's 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.

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 enrollment form.

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