Benefit Fund for Hospital and Health Care Employees -- Philadelphia and Vicinity

ENROLLMENT/CHANGE FORM

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK ONLY

1 LAST NAME | FIRST NAME | M.I.

STREET ADDRESS | APT. NO.

CITY | STATE | ZIP

SOCIAL SECURITY NUMBER | HOME PHONE NUMBER | DATE OF BIRTH (MM — DD — YYYY)

E-MAIL ADDRESS

2 TYPE OF APPLICATION OR CHANGE

❑ New application ❑ Add family member ❑ Remove family member ❑ Change of address ❑ Name change

Complete applicable information in Section 6 on the other side of this form.

REASON FOR CHANGE

❑ Marriage ❑ Divorce ❑ Birth ❑ Death ❑ Other (specify) _____ Date of event MM — DD — YYYY

If removing a family member, please provide his/her current adress

Name	Address	City, State, ZIP

3 PERSONS TO BE COVERED (For additional dependents attach a separate list if necessary)

Attach a copy of a birth certificate or adoption papers for each child to be covered.
Attach a copy of your marriage certificate when your spouse is to be covered.

ADD	REMOVE	CONTINUE	NAME (include last name if different from applicant) LAST FIRST	SEX	DATE OF BIRTH MO DAY YEAR	SOCIAL SECURITY NUMBER	RELATIONSHIP TO YOU
			SELF	❑ M ❑ F	— —	— —	N/A
			SPOUSE	❑ M ❑ F	— —	— —	N/A
				❑ M ❑ F	— —	— —	
				❑ M ❑ F	— —	— —	
				❑ M ❑ F	— —	— —	

Indicate your Primary Care Physician selection on the attached Aetna Enrollment/Change Form

4 COVERAGE INFORMATION

Is your husband/wife employed at present? ❑ Yes ❑ No If yes, is employment ❑ Full time or ❑ Part time If spouse is employed, please provide name, address and telephone of employer below:

Name	Address	City, State, ZIP	Telephone

Does your husband/wife/dependent children have health insurance or other coverage? ❑ Yes ❑ No If yes, please provide name and policy/group number of insurance company/plan below:

Name of insurance company/plan	Policy/group number	Effective date of coverage

Does your husband/wife/dependent children have dental insurance? ❑ Yes ❑ No If yes, please provide name and policy/group number of insurance company/plan below:

Name of insurance company/plan	Policy/group number	Effective date of coverage

Does your husband/wife/dependent children have prescription insurance? ❑ Yes ❑ No If yes, please provide name and policy/group number of insurance company/plan below:

Name of insurance company/plan	Policy/group number	Effective date of coverage

5 EMPLOYMENT INFORMATION

At which 1199 institution do you now work? _____ Work starting date _____ ❑ Full time or ❑ Part time Hours per week _____

Your employer's address _____

City _____ State _____ ZIP _____

Do you have a second job at another 1199 institution? ❑ Yes ❑ No If yes, please provide the information requested below:

At which 1199 institution do you now work? _____ Work starting date _____ ❑ Full time or ❑ Part time Hours per week _____

Your employer's address _____

City _____ State _____ ZIP _____

Please turn this page over and complete the information on the other side.

6 CHANGE INFORMATION

NAME CHANGE (enter former name, last name first, and attach marriage certificate or other document which gives proof of legal name change) | FIRST NAME | M.I.

WRONG SSN (attach copy of Social Security card) — — | IF YOU REGISTERED CHILDREN IN SECTION 4 ON THE OTHER SIDE, INCLUDE A BIRTH CERTIFICATE FOR EACH CHILD YOU REGISTERED.

NEW SPOUSE ❑ WIFE or ❑ HUSBAND (enter last name first) | FIRST NAME | M.I.

SPOUSE SOCIAL SECURITY NUMBER — — | SPOUSE DATE OF BIRTH MM — DD — YYYY | DATE OF MARRIAGE MM — DD — YYYY | ATTACH COPY OF MARRIAGE CERTIFICATE

NEW CHILD ❑ SON or ❑ DAUGHTER (enter last name first) | FIRST NAME | M.I.

CHILD'S SOCIAL SECURITY NUMBER — — | CHILD'S DATE OF BIRTH MM — DD — YYYY | Is your child covered by health insurance other than the Benefit Fund? ❑ YES or ❑ NO | ATTACH BIRTH CERTIFICATE OR ADOPTION PAPERS

If your child is covered by other health insurance, what type of coverage does s/he have? (check all that apply)
❑ Medical ❑ Dental ❑ Hospitalization ❑ Prescription ❑ Vision ❑ Major Medical

Name of Insurance Company or Plan _____
Policy No. _____ Group No. _____ Effective date of coverage _____

NEW ADDRESS | APT. NO.

CITY | STATE | ZIP — | NEW HOME PHONE NUMBER ( ) —

NEW EMPLOYER

Name of new employer _____ Work starting date _____ ❑ Full time or ❑ Part time Hours per week _____

Your employer's address _____

City _____ State _____ ZIP _____

Name of former employer _____ Last date of work for former employer _____

7 BENEFICIARY INFORMATION — DEATH BENEFIT

Below, please name the person(s) to whom your Death Benefit is to be paid. Please provide ALL requested information. If your beneficiary is a minor, state her/his age and provide the name(s) of the person's parent(s) or guardian(s) in the "Remarks" section below. You may name more than one person to share the Death Benefit. Should you choose to do this, indicate the percentage each individual is to receive in the "Remarks" section below and indicate that ALL of your named beneficiaries are primary beneficiaries. Any person named as a secondary beneficiary will receive benefits only if the primary beneficiary dies before you.

PRIMARY BENEFICIARY INFORMATION

LAST NAME | FIRST NAME | M.I. | RELATIONSHIP OF THIS PERSON TO YOU

STREET ADDRESS | APT. NO.

CITY | STATE | ZIP —

SOCIAL SECURITY NUMBER — — | HOME PHONE NUMBER ( ) — | DATE OF BIRTH MM — DD — YYYY | AGE

SECONDARY BENEFICIARY INFORMATION

LAST NAME | FIRST NAME | M.I. | RELATIONSHIP OF THIS PERSON TO YOU

STREET ADDRESS | APT. NO.

CITY | STATE | ZIP —

SOCIAL SECURITY NUMBER — — | HOME PHONE NUMBER ( ) — | DATE OF BIRTH MM — DD — YYYY | AGE

8 REMARKS

_____

_____

_____

_____

Failure to sign and date this form or to provide any required documentation may delay processing of this form and thereby delay coverage for you and/or your dependent(s).

9 The foregoing statements are, to the best of my knowledge, true and complete. This information may be used for purposes of updating my Union records.

MEMBER'S SIGNATURE _____ TODAY'S DATE _____

PLEASE RETURN THIS FORM TO THE BENEFIT FUND
1319 LOCUST STREET · PHILADELPHIA, PA 19107