LAUNDRY AND DRY CLEANING WORKERS LOCAL 52 HEALTH & WELFARE TRUST FUND
MEDICAL, DENTAL, AND VISION INSURANCE ENROLLMENT FORM

PERSONAL INFORMATION:

Name of Employee _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Telephone _____ Sex (circle one) M F

Marital Status: (circle one) Married Domestic Partnership Single/Unmarried

Employer _____ Date of Hire _____

DEPENDENT CHILD(REN) – MEDICAL, DENTAL, AND VISION INSURANCE (see separate section for spousal/domestic partner dental/vision insurance):

Coverage is limited only to dependents living in the United States, except for dependents enrolled in the Trust Fund HMO Plan in Mexico. A dependent child is defined as the employee's children from date of birth to 26 years. Dependent children shall also mean stepchildren, including children of a domestic partner who reside with the employee and legally adopted children. You must enroll and contributions must be made on all eligible dependent children in order for any dependent child to be covered. However, if your dependent child is age 19 or older and is covered by another group plan through his/her employer and/or the employer of his/her spouse or domestic partner, you do not have to enroll them. **If you are claiming that any of your dependent children fall within this exception, please complete and sign the attached Appendix A form and submit proof of other group health coverage.**

Proof of birth, adoption, or placement for adoption of each child, as applicable, must be submitted with this completed form to the Administrative Office before coverage can start.

Dependent Child Medical Selection – If you have a dependent child, please select one of the two boxes below

☐ **I have dependent children and I am electing to enroll them for medical coverage**. I understand there is an employee contribution of $10 per month for one child or $20 per month for two or more children if I elect dependent children coverage. I hereby authorize payroll deductions by my employer for my employee contribution(s). I acknowledge and understand that I must enroll and make contributions on all eligible dependent children (except for dependent children age 19 or older and who are covered by another group plan through their employer and/or the employer of their spouse or domestic partner) in order for any dependent child to be covered.

☐ **I have dependent children and I am electing to waive the medical coverage for them**. If I elect to waive coverage, I understand I cannot enroll my dependent children until the next open enrollment period, unless there is a special qualifying event that allows me to enroll them sooner.

Dependent Child Dental and Vision Selection

☐ **I have dependent children and I am electing to enroll them for dental and vision coverage**. Dental and vision coverage for dependent children is free.

LIST NAME OF ALL DEPENDENT CHILDREN ELIGIBLE FOR ENROLLMENT (as defined above):

LAST NAME FIRST NAME	SEX	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1.				
2.				
3.				
4.				

SPOUSAL/DOMESTIC PARTNER – DENTAL AND VISION INSURANCE ONLY:

Coverage is limited only to spouses/domestic partners living in the United States. A dependent spouses/domestic partner is defined as the employee's spouse or domestic partner (registered with the Secretary of State of the state of California, or with a governmental entity pursuant to state or local law authorizing this registration or with an internal registry maintained by the employer of at least one of the domestic partners, and who meets certain other criteria). For information about enrolling domestic partners not registered with the Secretary of State and/or civilly united partners, please contact the Trust Fund Office at (562) 463-5060 or (800) 524-8687 for additional information and forms.

Proof of a marriage certificate for a spouse or a Secretary of State-issued domestic partnership certificate for a domestic partner or other proof of domestic partnership acceptable to the Trust Fund, must be submitted with this completed form to the Trust Fund Office before coverage can start.

Dependent Spouses/Domestic Partner Dental and Vision Selection
☐ **I have a dependent spouses/domestic partner and I am electing to enroll them for dental and vision coverage**. Dental and vision coverage for a dependent spouse/domestic partner is free.

LIST NAME OF SPOUSE/DOMESTIC PARTNER (as defined above):

LAST NAME FIRST NAME	SEX	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1.				

I certify that the above information is true and correct. I also understand that the Trust Fund requires proof of birth, adoption, or placement for adoption of my children, as applicable, a marriage certificate for my spouse and/or proof of domestic partnership when this Enrollment Form is submitted.

Date Signed _____ Signature of Employee _____

APPENDIX A: DEPENDENT CHILDREN EXEMPT FROM MEDICAL INSURANCE ENROLLMENT

The dependent child(ren) identified below is/are age 19 or older and is/are covered by another group plan through his/her employer and/or the employer of his/her spouse or domestic partner, and are exempt from enrollment.

LIST NAME OF ALL DEPENDENT CHILDREN YOU CLAIM ARE EXEMPT FROM ENROLLMENT (as defined above):

LAST NAME FIRST NAME	SEX	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	NAME OF EMPLOYER	NAME OF INSURER OF GROUP PLAN
1.						
2.						
3.						
4.						
5.						