SANTA MONICA UNITE HERE HEALTH BENEFIT TRUST FUND

www.santamonicauniteherefunds.org
Administered By: Benefit Programs Administration
Telephone • (866) 345-5189 • (562) 463-5075 • FAX (562) 463-5894

Enrollment & Beneficiary Designation Form

Name of Employee _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____

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

Marital Status (circle one): Single Married Divorced Widowed

Employer _____ Date of Hire _____

LIFE INSURANCE BENEFICIARY DESIGNATION: I hereby designate the following person(s) as my beneficiary for any life insurance benefits payable under the Health Benefit Fund.

Beneficiary Name: _____ (Please Print) **Relationship to me:** _____ (Spouse, Child Etc.)

Your Signature: _____ (Sign, Do NOT Print) **Date:** _____

LIST BELOW ALL OTHER PERSONS COVERED BY THIS ENROLLMENT. Only your spouse, domestic partner and eligible dependent children under the age of 26 may be included.

YOU MUST SUBMIT COPIES OF DOCUMENTATION (MARRIAGE AND/OR BIRTH CERTIFICATES) TO VERIFY AND CONFIRM THE ELIGIBILITY OF YOUR ENROLLED DEPENDENTS. YOU MUST ALSO PROVIDE THE SOCIAL SECURITY NUMBER FOR EACH ENROLLED DEPENDENT.

LIST NAME OF SPOUSE/DOMESTIC PARTNER AND ALL CHILDREN:

LAST NAME	FIRST NAME	SEX	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1.					
2.					
3.					
4.					
5.					
6.					

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

Date Signed _____ Signature of Employee _____

SEND COMPLETED ENROLLMENT FORM TO:

Santa Monica UNITE HERE Health Benefit Trust Fund
1200 Wilshire Blvd.; Fifth Floor
Los Angeles, Ca 90017-1906