MLK Care Enrollment/Change Form

MLK CARE

MLK Community Healthcare

SANTA MONICA UNITEHERE! HEALTH BENEFIT FUND

Santa Monica UNITE HERE
Health Benefit Trust Fund:
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA. 90017

Name of Employee _____ Social Security Number _____

Address _____

City _____ State _____ Zip Code _____

Gender M ☐ F ☐ Date of Birth _____

Marital Status Single ☐ Married ☐ Home phone _____

Cell phone _____ Email _____

Employer _____ Date of Hire _____

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

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 _____

Designated Primary Care Martin Luther King Community Healthcare Physician:

_____