SEIU Michigan Health and Welfare Fund

# ENROLLMENT AND ELIGIBILITY FORM

**PLEASE PRINT CLEARLY--- COMPLETE ALL SECTIONS --- SIGN AND DATE**

**SECTION 1 ----- EMPLOYEE/UNION MEMBER INFORMATION**

**Member's Name**: ______________________________________________ **Gender: Male Female**
First Name Middle Initial Last Name (Circle One)

**Home Address:** ________________________________________________________________
House Number Street Name Apartment No.

**City:** ______________________________ **State:** MI **ZIP:** ___________ **County:** ___________

**Cell Phone #** (______) __________ -_____________ **Date of Birth:** _______/_______/________
Month Day Year

**Social Security Number:**

| # | # | # | # | # | # | # | # | # |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

**Email:** ________________________________________________ **Marital Status: Single Married**
(Circle One)

**SECTION 2 ----- EMPLOYER/CBA INFORMATION** **Master Cleaning Contract _____ (√) or Site Contract _____ (√)**

**Employer's Name:** ________________________________________________________________

**Work Site:** ____________________________________________ **Date of Hire:** _____/_____/_____
Building Name or Number / Street Name / City Month Day Year

**Job Status: Full time _____ On-Call/Swing Shift: _____** (eligible after 15 months/master) **Hours per Week: ______**

**Job Position:** ______________________________________ **Union Seniority Date:** ____/ ____/ ____

**SECTION 3 ----- INSURANCE INFORMATION**

**Are any of your dependents included in a divorce decree or a court order for health care coverage? Yes _____ No _____**
**If yes, please submit a copy of the divorce decree or a copy of the court order.**

✔ **Insurance Selection**: **Single Coverage ______ 2-Party Coverage ______ Family Coverage ______**

***Fund Benefit Package Includes: (1) medical (2) prescription (3) dental (4) vision (5) life insurance (employee only) and (6) short-term disability (employee only) per your Collective Bargaining Agreement with SEIU Local 1 and your Employer.***

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**List any Family Members you are covering: Copy of marriage certificate must be on file to enroll a spouse.**

**Spouse's Name:** ________________________________________________________________

**Spouse's SSN:** ______________________________________ **Spouse's DOB:** __________________

**Gender: Male _______ Female _________ Same Address as Above: Yes _______ No ________**

**If Address is Different:** ______________________________________________________


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List any additional Family Members you are covering: Copy of birth certificate or adoption decree must be on file to enroll dependents.

**Dependent's Name:** ______________________________

**Dependent's SSN:** ____________________ **Dependent's DOB:** ____________

**Relationship: Son _____ Daughter ______** **Same Address as Above: Yes _______ No _______**

**If Address is Different:** ______________________________

**Section 4----Medicare: If over 65 or have been diagnosed with a disability, please complete. (NEED COPY OF YOUR CARD)**

**Name:** ______________________________

**Medicare Claim Number:** ______________________________

**Part A** **Effective Date:** ______________________________

**Part B** **Effective Date:** ______________________________

**Section 5---Coordination of Benefits: If you have other insurance coverage through the military or retirement, please complete.**

**IMPORTANT NOTE: IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, PARTICULARLY COVERAGE THROUGH THE STATE OF MICHIGAN (MEDICAID), YOU SHOULD COMPARE THE BENEFITS BEFORE DECIDING TO ENROLL IN THE SEIU MICHIGAN HEALTH AND WELFARE FUND PLAN. SEIU MICHIGAN HEALTH AND WELFARE FUND COVERAGE CONTAINS CO-PAYS, DEDUCTIBLES, AND COINSURANCE.**

**IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, NOT THROUGH THE STATE, CONTACT LYNN WEAVER AT THE BENEFITS OFFICE AT 248-645-6550 TO ESTABLISH COORDINATION OF BENEFITS.**

**Name of Other Insurance:** ____________________ **Policy Number:** ____________

**Group Number:** ____________ **Subscriber's Name:** ____________________

**Section 6---Member's signature required for enrollment to be processed, please sign.**

**Subscriber's Signature:** ______________________________

**Today's Date:** ______________________________
*(Date you are signing this form)*

**Social Security Number:** | # | # | # | - | # | # | - | # | # | # | # |

**Insurance Effective Date:** ______________________________
*(When insurance begins)* Month Day Year

**PLEASE DO NOT WRITE BELOW THIS LINE. PLEASE DO NOT WRITE BELOW THIS LINE. PLEASE DO NOT WRITE BELOW THIS LINE.**

| | For Office Use Only | Insurance Providers | Group # | Date Completed | Initials | Effective Date |
|---|---|---|---|---|---|---|
| 1 | Health and Welfare | Enter in Billing System | SEIU MI H&W Fund | | | |
| 2 | Medical | Personify Health/Aetna Network | 114512 | | | |
| 3 | Prescription | EHIM—Employee Health Ins. Mgt. | 50001539-01 | | | |
| 4 | Dental | A.D.N. Administrators | 10190 | | | |
| 5 | Vision | Eye Med | 1008033 | | | |
| 6 | Invoice Employer | Copy for Member's File | SEIU MI H&W Fund | | | |



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