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 (Check One)

Home Address: _____
House Number Street Name Apartment No.

City: _____ **State:** *MI* **ZIP:** _____ **County:** _____

Cell Phone # _____ **Date of Birth:** _____

☐ **I accept and DO want to receive text messages.** ☐ **I decline and DO NOT want to receive text messages.**

Social Security Number: _____

Email: _____ **Marital Status:** ☐ **Single** ☐ **Married**
(Check One)

SECTION 2 ----- EMPLOYER/CONTRACT INFORMATION **Master Cleaning Contract** ☐ **(√) or Site Contract** ☐ **(√)**

Employer's Name: _____

Work Site: _____ **Date of Hire:** _____
Building Name or Number / Street Name / City

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.

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: _____

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

Dependent 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:** _____

Subscriber's Signature: _____

Today's Enrollment Date: _____

Social Security Number: _____

Insurance Effective Date: _____

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	Cigna PPO (OAP 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			