

SEIU HEALTH & WELFARE FUND ENROLLMENT/WAIVER FORM

Please Print Clearly

FIRST NAME: _____ LAST NAME: _____

SSN: _____ - _____ - _____ DATE OF BIRTH: ____ / ____ / ____ SEX: MALE FEMALE

HOME STREET ADDRESS/APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: (CIRCLE ONE) COOK DUPAGE KANE LAKE WILL OTHER _____

EMPLOYER: _____ DATE OF HIRE: _____

BUILDING NAME _____

BUILDING ADDRESS _____

Children for enrollment – Eligible children include child by birth or legal adoption that are age 26 or younger.

FIRST NAME	LAST NAME	DOB	SSN	RELATIONSHIP (Circle one)
				Son Daughter
				Son Daughter
				Son Daughter

CHOOSE ONE:

- I **DO NOT** want to enroll in the health insurance plan. I understand that I am waiving this coverage and that I will not be able to enroll until the next open enrollment period or unless I have a qualifying event.
- I want to enroll in the health insurance plan for **MYSELF ONLY**. I authorize my employer to process my payroll deduction (according to the CBA between my employer and the SEIU local 1). I understand that I cannot drop coverage until the next open enrollment period or unless I have a qualifying event.
- I want to enroll in the health insurance plan for **MYSELF AND MY ELIGIBLE CHILDREN** listed above. I authorize my employer to process my payroll deduction (according to the CBA between my employer and the SEIU local 1). I understand that I cannot drop coverage until the next open enrollment period or unless I have a qualifying event.

Signature

Date

By signing this form I attest that all information provided is true and correct

For Employer Use Only

Received by

Date