SEIU HEALTH & WELFARE FUND ENROLLMENT/WAIVER FORM
CHICAGO METRO & STATE OF IL SECURITY OFFICERS

FIRST NAME: _____ LAST NAME: _____

SSN:____ _____DATE OF BIRTH: _____/_____/ _____ SEX: MALE FEMALE

HOME STREET ADDRESS/APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMPLOYER: _____ DATE OF HIRE: _____

BUILDING NAME _____

BUILDING ADDRESS_____

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

FIRST NAME	LAST NAME	DOB	SSN	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 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 SEIU Local 1). I understand I cannot drop coverage until the next open enrollment period 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 SEIU Local 1). I understand that I cannot drop coverage until the next open enrollment period unless I have a qualifying event.

_____ _____

Signature **Date**

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

For Employer Use Only

_____ _____

Received by **Date**