

20. DEPENDENT CHILDREN INFORMATION

NOTE: YOU MUST ATTACH A BIRTH CERTIFICATE FOR NEWLY ADDED DEPENDENTS. YOU MUST ATTACH A COPY OF A SCHOOL CERTIFICATE OF ENROLLMENT FORM FOR ANY DEPENDENT CHILD STUDENT AGE 19 TO 23.

FULL NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY #	DATE OF BIRTH	SEX	RELATIONSHIP TO EMPLOYEE
	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:				
	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:				
	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:				
	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:				
	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:				

21. DEPENDENT COORDINATION OF BENEFITS INFORMATION

IS DEPENDENT COVERED BY ANOTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF MEDICARE ELIGIBLE ATTACH A COPY OF MEDICARE CARD	IF YES - SHOW NAME OF COVERED EMPLOYEE:	SOCIAL SECURITY NUMBER / /
IF YES, PLEASE INDICATE TYPE OF COVERAGE: <input type="checkbox"/> MEDICAL <input type="checkbox"/> VISION <input type="checkbox"/> RX	EFFECTIVE DATE OF COVERAGE:	GROUP OR I.D NUMBER:
NAME OF OTHER PLAN:	ADDRESS:	

22. NOTICE OF CHANGE: ADD DEPENDENT(S) DELETE DEPENDENT(S)
IF ADDING OR DELETING A DEPENDENT SPOUSE - MARRIAGE CERTIFICATE OR DIVORCE DECREE MUST BE ATTACHED

MARRIAGE <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER <input type="checkbox"/>	LAST NAME:	FIRST NAME:	SOCIAL SECURITY # / /	DOB / /
IF OTHER - PLEASE EXPLAIN:				
MARRIAGE <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER <input type="checkbox"/>	LAST NAME:	FIRST NAME:	SOCIAL SECURITY # / /	DOB / /
IF OTHER - PLEASE EXPLAIN:				

23. BENEFICIARY DESIGNATIONS **FAMILY HEALTH PLAN ONLY**** BENEFICIARY DESIGNATIONS**

LIFE INSURANCE (LOCAL 49 MEMBERS ONLY)		VACATION BENEFITS (LOCAL 49 MEMBERS ONLY)	
<input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY. DO NOT COMPLETE INFORMATION BELOW		<input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY. DO NOT COMPLETE INFORMATION BELOW	
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
RELATIONSHIP	SS#	RELATIONSHIP	SS#
ADDRESS		ADDRESS	
CITY	STATE ZIP	CITY	STATE ZIP
NAT'L PENSION FUND (LOCAL 49 MEMBERS ONLY)		SASMI BENEFITS (LOCAL 49 MEMBERS ONLY)	
<input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY. DO NOT COMPLETE INFORMATION BELOW		<input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY. DO NOT COMPLETE INFORMATION BELOW	
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
RELATIONSHIP	SS#	RELATIONSHIP	SS#
ADDRESS		ADDRESS	
CITY	STATE ZIP	CITY	STATE ZIP
<input type="checkbox"/> PLEASE CHECK HERE IF YOU WOULD LIKE TO RECEIVE NEW MEDICAL ID CARDS			