

# SEIU HEALTH & WELFARE FUND ENROLLMENT/WAIVER FORM

## SEIU Local 26 Airport Workers

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: MALE FEMALE

HOME STREET ADDRESS/APT #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

NAME OF EMPLOYER: \_\_\_\_\_

EMPLOYEE NUMBER: \_\_\_\_\_ DATE OF HIRE: \_\_\_\_\_

*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

- 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 26). 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 26). 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**