SEIU HEALTH & WELFARE FUND ENROLLMENT/WAIVER FORM

SEIU Local 26 Security Officers

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

Updated 10/2024