LABORERS FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA
220 Campus Lane, Fairfield, CA 94534-1498 * Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530
E-Mail Address: customerservice@norcalaborers.org * Website: http://www.norcalaborers.org

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ENROLLMENT FORM

IMPORTANT: By submitting this form, you understand that the information will be used by the various Trust Funds administered by the Laborers Funds Administrative Office of Northern California that are applicable to you for the purpose of communication, enrollment and benefit designation. Complete only the sections that apply.

PART I. PARTICIPANT INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST	MIDDLE	LAST	

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS *(IF DIFFERENT FROM ABOVE)*	CITY	STATE	ZIP CODE

HOME PHONE ☎ : CELL PHONE ▮ :	E-MAIL ADDRESS, IF ANY	LOCAL UNION NO.	☐ *Cuando posible* prefiero recibir información de beneficios en Español.

DATE OF BIRTH MONTH DAY YEAR	GENDER	PRESENT MARITAL STATUS MONTH DAY YEAR	PRIOR MARRIAGE* (*if applicable*)
/ /	☐MALE ☐FEMALE	☐NEVER MARRIED ☐SINGLE ☐MARRIED→ *(date of marriage)* → / /	NAME OF EX-SPOUSE _____ DATE OF DIVORCE _____

PART II. LABORERS HEALTH AND WELFARE PLAN

A. Enrollment - Dependent Information (Attach a separate sheet for any dependent with different address than above)

IMPORTANT: Add new or delete previously enrolled dependents below. The term "**Dependent**" is defined in your Health and Welfare Plan and includes your legal spouse or your *domestic partner (*only if you are an Active Employee), your or your *domestic partner children under age 26 regardless of marital status or unmarried children age 26 or older who are totally handicapped. If you are a Retired Employee, you must pay the applicable monthly premium for dependent coverage.

Unless documents have been previously provided, you are required to mail the applicable document(s) below to the Fund Office to substantiate your relationship to your dependent(s). **Write your SSN on each of the document for identification purposes.**

	Document Required:
SPOUSE	Marriage Certificate. If you are divorced and you are either deleting your ex-spouse or adding a new spouse, you must provide a copy of the Final Dissolution of Marriage. Your ex-spouse will lose dependent status as of the date of dissolution.
DOMESTIC PARTNER	Domestic Partners Certificate and written statement from your employer certifying that it has entered into a job contract with the State of California, County of San Mateo, City or County of San Francisco, City of Oakland or Sacramento.
NATURAL/STEP/ADOPTED CHILD	Birth Certificate and legal adoption document for adopted child.
LEGAL GUARDIANSHIP	Legal Guardianship papers or documents from a Court appointing you as the legal guardian.
FOSTER CHILD	Proof of foster child placement or custody from a placement agency or a Court appointing you as the foster parent.

Add or Delete	Relationship	Gender	Name (First, Middle Initial and Last)	Date of Birth Month Day Year	Social Security No.
☐ Add ☐ Delete	Spouse or Domestic Partner	☐ Male ☐ Female		/ /	- -
☐ Add ☐ Delete	Child	☐ Male ☐ Female		/ /	- -
☐ Add ☐ Delete	Child	☐ Male ☐ Female		/ /	- -
☐ Add ☐ Delete	Child	☐ Male ☐ Female		/ /	- -

- **You will be responsible for any incorrectly paid claims resulting from your failure to notify the Fund Office of changes in dependent status, such as, but not limited to, death, divorce, or loss of legal guardianship.**
- **This form will be returned if you fail to provide the dependent's date of birth and Social Security number.**

B. Other Insurance Coverage Information

Do any of your dependents listed on the reverse side of this form have another employer-sponsored medical, prescription drug, dental and/or vision Plan coverage either as an employee or as a dependent?

☐ **No ::** Skip this section. **NOTE:** You must notify the Fund Office *immediately* if any dependent obtains other insurance for any reason, such as entitlement to Medicare, Medi-Cal, Medicaid, disability, or through employment.

☐ **Yes ::** Provide information below. If the other insurance applies to all dependents listed on the front side of this form, complete the box below. If one or more of your dependents have more than one other insurance, make a photocopy of this section and complete for each dependent.
Do(es) the dependent(s) live with you?
☐ **Yes** ☐ **No ::** If 'No' with whom does the child live? Name: _____ Relation: _____

If you are divorced, provide copy of any court orders pertaining to custody and/or health coverage for the dependent.

Name(s) of dependent(s) covered by other insurance:	
Name of Insured or policy holder	Relationship to Participant
Social Security number or ID number of Insured	Name of employer providing the coverage

TYPE OF BENEFITS PROVIDED	POLICY NUMBER	EFFECTIVE DATE	DEPENDENTS COVERED?
NAME & ADDRESS OF MEDICAL PLAN			☐ YES ☐ NO
NAME & ADDRESS OF DENTAL PLAN			☐ YES ☐ NO
NAME & ADDRESS OF PRESCRIPTION DRUG PLAN			☐ YES ☐ NO
NAME & ADDRESS OF VISION CARE PLAN			☐ YES ☐ NO

PART III. BENEFICIARY INFORMATION - Designation of Beneficiary for Death Benefits

1. **Health and Welfare Plan (Active and Special Plans only)** – *You may designate any beneficiary you wish. Any death benefit due from your Health and Welfare Plan will be paid to your named beneficiary below. Refer to Article III of your Plan for more information.*
2. **Vacation-Holiday Trust Fund** – *You may designate any beneficiary you wish. Any unpaid Vacation-Holiday benefit due you will be paid to your named beneficiary below.*
3. **Pension and Annuity Plans** - *If you are married, any pre or post-retirement pension benefits due will be paid to your surviving spouse and not to your named beneficiary as retirement plans are subject to community property. Refer to the provisions of your Plan or contact the Fund Office for more information regarding death benefits.*

☐ Check here if you want to designate more than one person for one or more of the Funds. The necessary form will be mailed to you.
☐ Check here if you **do not** want to change your previously designated beneficiary.

If you do not designate a beneficiary below and also do not check the box above, any death benefits payable, subject to each Plan's provision, will be paid equally to one or more of your surviving relatives as this beneficiary designation replaces the form you have previously filed, if any, and will be effective upon receipt by the Fund Office.

******Please do not list 'self' as your beneficiary******

SSN OF BENEFICIARY	NAME: FIRST MIDDLE LAST	RELATIONSHIP
MAILING ADDRESS - STREET		
CITY STATE ZIP CODE		HOME PHONE ☎ : CELL PHONE :

PARTICIPANT STATEMENT – You MUST date and sign form

I hereby certify under penalty of perjury under the laws of the State of California that the information given in this form is true, correct and complete to the best of my knowledge.

DATE: SIGNATURE: