UNITED ADMINISTRATIVE SERVICES

. GROUP INSURANCE ENROLLMENT CARD

— CLAIMS CANNOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE (Please Print)

F r Administrator Use Only			Employer Us Only
Effective Date MO.DAY YR.	Life Amount	# Covered	Check One: New Hire / Change Card
			☐ / ☐

Employer's Name

San Mateo Electrical Workers Health Care Plan

Employer Phone Nnmber

Employee's Name (Last, First, Ml) | Soc. Sec. No. | Date of Birth | Sex DMaie 0 Female

Employee's Street Address | City | State | Zip Code | Telephone Nnmber

Occupation/Job Title | Date Employed Full Tune | Date Employment Reinstated | fir's Worked Weekly | Monthly Salary

Marital Status

0 Single O Married OWidowed 0 Legally Separated ☐Divorced Date of Marriage MO. DAY YR.

Children ☐ Yes ☐ No

ENROLLMENT FOR INSURANCE (Please choose appropriate plan)

☐ MEDICAL ☐ PP0 ☐ EP0 ☐ HMO OOTHER---------- –

☐ DENTAL ☐ VISION ☐ LIFE INSURANCE OP0S

I elect Dependent Coverage for ☐ Spouse Only ☐ Spouse & Child(ren) ☐ Ochild(ren) only

Give the following information for each dependent to be insured:

Name {Last, First, Ml)	Relation.ship	Date of Birth	Soc. Sec. No.	Employer/Name of School* Please provide name of ,chool if any dep dents are full time students

Name, address and policy number of any other health carrier:

Please list addresses on all dependents noted above if not residing with employee:

BENEFICIARY INFORMATION ****Please note: The below area MUST be completed if applying for Life Insurance

Please complete an attached list if **you want to name more persons than provided for on this form,**

Name Of Beneficiary {Last, First, Ml) | Date of Birth | Relationship to Employee

Street Address of Beneficiary | City | **State** | Zip Code

If the beneficiary dies before me, I designate as contingent beneficiary:

Name of Contingent Beneficiary {Last, First, Ml) | Date of Birth | **Relationship to Employee**

Street Address of Contingent Beneficiary | City | **State** | Zip Code

REFUSAL OF INSURANCE (Complete only if not enrolling for all available coverages.)

If the plan requires contributj.ons, :and I have refused the insurance, I understand that if I request coverage for myself and/or current or future eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and that the insurance company reserves the right to reject my request. However, I and my dependents will not be required to provide proof of insurability for major medical coverage if I and lllY dependents a) are insured under the plan or policy listed below, and b) provide documentation of that coverage and request enrollment in this plan within 30 days of the date that coverage terminated due to end of employment, death of a spouse, divorce, or where a court has ordered coverage be provided for a spouse or minor child.

I decline the following employee coverage/s available to me:

☐ Medical Only ☐ Dental ☐ other

because: Or am insured under another policy or group plan (please indicate information below) **Oother reasons**

Employer's Name. C.arrier Name.

Idecline the following coverage/s available to my •0 Spouse only ☐ Spouse &child(ren) Children only:

☐ Medical Only ☐ Dental ☐ other

because: ☐ My Dependents are insured under another policy or group plan (please indicate information below) Oorher reasons,

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance; (3) state that I became an employee on the date stated above, and do currently work the number of hours per week stated above; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. I understand no coverage will be effective until I am actively at work at my regular place of employment on or after the effective date of the Master Policy. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an **application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

1 have reviewed the statements on this application and they are true and complete to the best of my knowledge.

Signature of Employee | Date | Authorized Signature of Employer | Title