PLAN 150 ENROLLMENT
(H.E.R.E.I.U. Welfare Fund)

Please check one:

☐ New Enrollee
☐ Adding Dependents

☐ Dental Plan Change ► ☐ to Dental Plan A ☐ to Dental Plan B

SECTION 1: YOUR INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	BIRTHDATE	SEX
					☐ Male ☐ Female

HOME ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE

LOCAL UNION	EMPLOYER COMPANY NAME	JOB CLASSIFICATION	DATE HIRED	LANGUAGE PREFERENCE	E-MAIL ADDRESS
				☐ English ☐ Spanish ☐ Other _____	

SECTION 2: DEPENDENTS

Complete this section to enroll for coverage of your spouse and/or eligible children. Eligible dependents include your lawful spouse (same sex domestic partner) and your unmarried children, including stepchildren, adopted children, and children for whom you are a court-appointed guardian, up to age 19 (or 23 if a full-time student), according to the Plan. For spouse, you will need to bring a **certified** copy of your marriage certificate. For children, you will need to bring a **certified** copy of each child's birth certificate. For domestic partner (same sex), please contact Customer Service (702) 733-9938 for additional information.

LAST NAME OF SPOUSE	FIRST NAME OF SPOUSE	M.I.	SEX (M/F)	SOCIAL SECURITY NUMBER	DATE OF MARRIAGE	DATE OF BIRTH	VERIFIED
LAST NAME OF DEPENDENTS	FIRST NAME OF DEPENDENTS						

SECTION 3: CHOOSE ONLY ONE DENTAL PLAN

You may change dental plans once a year in addition to the dental open enrollment. If you have never made a dental choice and do not make a choice at this time, you and your family will automatically be placed in Plan A. Refer to the Dental Plan Benefit brochure to help you decide which dental plan to choose.

☐ **Plan A: Nevada Pacific Dental** Contracted Plan Dentist

Services are provided by a dentist that has a contract with the Fund. Many services have very little out-of-pocket costs to you. You can change dentists anytime.

You must select a dentist from the 'accepting new patients' list on the attached map. Please list the name and letter of the office selected:

DENTAL OFFICE NAME: _____ DENTAL OFFICE LETTER: _____

☐ **Plan B: You can go to any licensed dentist you prefer.** You usually pay more for dental care that is not preventative (see chart below).

Comparison of dental benefits: Out-of-pocket costs to you (*estimated)*

SERVICE	PLAN A	PLAN B*
Examination	no charge	$50 +
Complete Mouth X-Rays	no charge	$100
Teeth Cleaning	no charge	$88
One Surface Silver Filling	no charge	$100
Crown	$120	$1000

* Your actual out-of-pocket costs will depend on how much your dentist charges for these services.

SECTION 4: OTHER INSURANCE COVERAGE

ARE YOU OR ANY OF YOUR DEPENDENTS INSURED UNDER ANY OTHER GROUP MEDICAL OR DENTAL INSURANCE – (including Culinary, Student, Accident, or government plan)? If yes, complete the next lines.

Please Note: If your dependent spouse is eligible for health benefits at their work, Culinary may require your spouse to enroll for benefits at their job to be a covered dependent in the Culinary Plan. * See employer list.

Is your spouse employed? ☐ **YES** - Please complete questions 1 and 2 below. ☐ **NO** - Please go to **SECTION 5**

1. Employer's Name:

2. Is your spouse covered by his/her employer Health Plan? ☐ **YES** - Please complete 2a. ☐ **NO** - Please complete 2b.

2a. If YES, please indicate:

Insurance Name: _____

Address: _____

Phone Number: _____

Policy Number: _____ Effective Date: _____

Insurance Type: ☐ Single ☐ Family

Coverage Type: (please check all that apply) ☐ Medical ☐ Dental

2b. If NO, please provide reason:

☐ Insurance is not offered

☐ Part Time Employee – not eligible for health benefits

☐ Spouse eligible but not signed up

☐ New employee, will be eligible _____

List below your other Dependents insured under other Health Plan	Employer Name and Address	Name, Address, and Effective Date of Insurance Co.	Policy #	Type of Coverage:
				Please check all that apply: ☐ Single ☐ Family ☐ Medical ☐ Dental
				Please check all that apply: ☐ Single ☐ Family ☐ Medical ☐ Dental

SECTION 5: CONSENT INFORMATION

By my signature below, I acknowledge that the Fund and its authorized agents may use and disclose health information for purposes related to evaluating, processing, and reviewing my claims or my dependent's claims, and I consent to the disclosure of information requested by the Fund by any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator.

This consent will be valid for the entire period of my eligibility and my dependent's eligibility under the Fund's plan of benefits.

I understand and agree that any intentional omissions or incorrect statements made on this form may result in the termination of my and/or my dependents' health benefits.

I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

Signature **Date**

7/08