CAREFULLY READ THE BACK OF THIS FORM BEFORE YOU COMPLETE THIS SIDE

TCU-MTA

HEALTH AND WELFARE TRUST FUND

Medical Plan Enrollment Form

562-463-5090 • 800-427-5342

TYPE OF ACTION
- ☐ Enrollment
- ☐ Dependent Enrollment

I -SOCIAL SECURITY NUMBER ▶ ☐☐☐-☐☐-☐☐☐☐

EMPLOYEE IDENTIFICATION

Last Name	First		Initial
Street Address			
City,	State		Zip Code
Dept. / Badge #	DATE OF BIRTH: Month Day Year		SEX (Check one): ☐ Male ☐ Female
Telephone No. ( )			

II -DEPENDENTS (SEE REVERSE SIDE OF THIS FORM FOR DEPENDENT ELIGIBILITY REQUIREMENTS)

	Full name of spouse and dependents to be covered			Relationship	Sex (Circle)	Date of Birth			Social Security Number if one is assigned
						Month	Day	Year	
1	Last Name	First	Initial		M F				
2	Last Name	First	Initial		M F				
3	Last Name	First	Initial		M F				
4	Last Name	First	Initial		M F				
5	Last Name	First	Initial		M F				

III - OTHER INSURANCE

Do you have other Group Health Insurance? ☐ **NO** ☐ **YES**

OTHER

Name of policyholder and his/her employer	Policy & Group No.	Insurance company's name and adddress
Policyholder	Policy/Contract Number	
Employer	Group Number	

MEDICARE

Full name of MEDICARE covered person			Hospitalization (Part A)	Medicare (Part B)	MEDICARE Number
Last Name	Fist	Initial	(Circle One) **YES NO**	(Circle One) **YES NO**	
Last Name	First	Initial	(Circle One) **YES NO**	(Circle One) **YES NO**	

IV – AUTHORIZATION

I HEREBY AUTHORIZE MY EMPLOYER, UNTIL THIS AUTHORIZATION IS REVOKED BY WRITTEN NOTICE, TO DEDUCT EACH MONTH FROM ANY EARNED OR ACCRUED WAGES DUE TO ME, THE AMOUNT APPLICABLE TO THE COVERAGE OPTION I HAVE SELECTED. I HEREBY CERTIFY THAT THE ABOVE INFORMATION AND ANY ATTACHMENTS THERETO ARE TRUE AND CORRECT. I UNDERSTAND THAT MISREPRESENTATION OR FALSIFICATION WILL SUBJECT ME TO PENALTIES AND POSSIBLE LEGAL ACTION

DATE _____ EMPLOYEE'S SIGNATURE _____

RETURN COMPLETED ENROLLMENT FORM TO:

TCU-MTA HEALTH AND WELFARE

ADMINISTRATIVE OFFICE

1200 Wilshire Blvd., Fifth Floor

Los Angeles, CA 90017

DEPENDENT BENEFIT PROVISIONS:

The Plan Defines "Dependent" as:

1. **Your lawfully married spouse or registered Domestic Partner.**
2. **Your child(ren) who is /are 25 years of age or younger, including:**
    - **Your legally adopted child or foster child or those of your spouse or domestic partner**
    - **Your stepchild (i.e., the child of your lawfully married spouse or Domestic Partner)**
    - **A child for whom you, your spouse, or your Domestic Partner have been designated the court appointed legal guardian or conservator. Proof of legal guardianship or conservatorship must be submitted to the Administrative Office upon request.**
3. **Your child(ren) who is 26 years of age or older if the child is disabled and incapable of self-sustaining support as a result of a mental retardation or physical handicap that occurred prior to reaching age 26. Written evidence of disability must be submitted within 31 days of attainment of the age limit and must be periodically reconfirmed to the Administrative Office upon request. This disability extension will continue until the earlier of: (1) the date the child ceases to be eligible for reasons other than age; (2) the date the child ceases to be disabled; or (3) the 31st day after the Trust requests additional proof of the child's disability and you fail to furnish such proof.**

NOTE: Enrollment is accomplished by completing and filling an enrollment card with Trust Administration office.

Eligible newborns must be enrolled within 30 days of birth, for their coverage to be effective from the date of birth. Other dependents must be enrolled within 30 days of becoming eligible and if they are not so enrolled, will only be added if enrolled thereafter during the Open Enrollment period.

WAIVER OF COVERAGE

If you have eligible dependents enrolled elsewhere under another group health plan, you need not enroll them under this Plan. However, at the time of your enrollment you should sign a waiver card for the dependents. Should their coverage under the other plan cease due to termination of employment you will then be able to enroll them in this Plan within 30 days after their coverage ends, if a signed waiver card is on file.

Note: If you do not have a waiver card on file, you will have to wait until the next Open Enrollment period to enroll dependents.

Once you are in the TCU-MTA Health & Welfare Trust Fund, it is your obligation to notify the Administration Office each time a dependent is added or ceases to be eligible. Failure to do so may result in an inaccurate payroll deduction or omission from coverage.