SEIU HEALTH & WELFARE FUND ENROLLMENT/WAIVER FORM
SEIU Local 26 Security Officers

FIRST NAME: _____ LAST NAME: _____

SSN: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

DATE OF BIRTH: _____ / _____ /_____ SEX: MALE FEMALE

PHONE NUMBER: _____ EMAIL ADDRESS: _____

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
				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