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SOUTHERN CALIFORNIA DRUG BENEFIT FUND FAMILY INFORMATION FORM

Return to:
P.O. Box 27920
Los Angeles CA 90027-0920

PARTICIPANT INFORMATION

Social Sec. No. _____ - _____ - _____

First Name _____ Last Name _____

Address _____ City/State/Zip _____

Current Legal Status (please circle)

SINGLE -- MARRIED -- DIVORCED -- LEGALLY SEPARATED -- DOMESTIC PARTNER*

Participant's Date of Birth ____ / ____ / _____

Participant's Phone Number (____) ____ -- _____

Participant's Date of Marriage ____ / ____ / _____

Participant's Date of Divorce/Legal Separation ____ / ____ / _____

Does Participant have Medicare coverage?
(circle) Yes No

*A Certificate of Domestic Partnership issued by the State of California is required to qualify your partner for Fund benefits.

SPOUSE/DOMESTIC PARTNER INFORMATION

Social Sec. No. _____ - _____ - _____

First Name _____ Last Name _____

Street Address _____ City/State/Zip _____

Date of Birth _____ Is Spouse/DP employed? (Circle) Yes No If "yes," employer name _____

Employer Address _____

Employer's City/State/Zip _____ Phone _____

Does Spouse/DP's employer offer health coverage? (circle) Yes No (If circled answer is "No," please proceed to Dependents section.)

If "yes," has s/he elected such coverage? (circle) Yes No Effective date _____ Group no. _____

If Participant's spouse/domestic partner's employer does offer health coverage, but s/he hasn't elected such coverage, on what date does s/he become eligible under his/her employer's plan? Date: _____

What type of insurance is offered? (Please circle)

Family Single

Please circle all covered benefits which apply:

Medical Dental Vision Prescription

Does Participant's Spouse/DP have other insurance coverage? (circle) Yes No If "yes," please provide the following information:

Name of insurance company _____

Address _____ City/State/Zip _____ Phone _____

Is s/he retired? (circle) Yes No Does s/he have Medicare coverage? (circle) Yes No

OTHER DEPENDENTS

New laws require the health fund to obtain Social Security numbers on all dependents. Please use legal name or name that appears on birth or marriage certificate.

First Name, Middle Initial, Last Name	Social Sec. No.	Sex	Marital Status	Does this dependent have other coverage?	Is this dependent eligible for Medicare?
_____	____ - ____ - ____	M ___ F ___	_____	Yes ___ No ___ Not sure ___	Yes ___ No ___ Not sure ___
_____	____ - ____ - ____	M ___ F ___	_____	Yes ___ No ___ Not sure ___	Yes ___ No ___ Not sure ___
_____	____ - ____ - ____	M ___ F ___	_____	Yes ___ No ___ Not sure ___	Yes ___ No ___ Not sure ___
_____	____ - ____ - ____	M ___ F ___	_____	Yes ___ No ___ Not sure ___	Yes ___ No ___ Not sure ___
_____	____ - ____ - ____	M ___ F ___	_____	Yes ___ No ___ Not sure ___	Yes ___ No ___ Not sure ___
_____	____ - ____ - ____	M ___ F ___	_____	Yes ___ No ___ Not sure ___	Yes ___ No ___ Not sure ___

I hereby certify that the forgoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I agree to promptly notify the Fund Trustees in writing in the event of (1) a change in marital status due to marriage, divorce or legal separation (2) the death or disability of a person named herein (3) the birth or adoption of a dependent child and/or (4) a child's dependent status changing due to age, student status, marriage or financial independence.

PARTICIPANT'S SIGNATURE: _____ DATE ____ / ____ / ____

I hereby certify that all of the information provided on this form is true and correct. I hereby authorize my employer, _____, to release information regarding my employer's health insurance plan (including the Summary Plan Description) and my eligibility for coverage under that Plan to the Southern California Drug Benefit Fund. I understand the authorization shall remain in effect as long as I am eligible for benefits under the Southern California Drug Benefit Fund. I understand that the purpose and scope of this authorization is to allow the Southern California Drug Benefit Fund to verify with my employer whether I am eligible to collect or obtain coverage under my employer's health plan.

SPOUSE/DOMESTIC PARTNER'S SIGNATURE: _____ DATE ____ / ____ / ____

Failure to complete and return this document may result in a delay in the processing of claims submitted to this Trust Fund for payment. Completion of this form does not guarantee or establish eligibility for benefits.