



**COMPLETE THIS FORM to add a newly eligible child age 19 up to age 26 to your health care coverage. List only newly eligible children below. Please read the instructions on the other side of this form and print carefully. \*Coverage will end the last day of the month in which your child reaches age 26, unless coverage is terminated earlier.**

### 1. PARTICIPANT INFORMATION

Last Name		First Name		Mid. Initial	Social Security Number	
Mailing Address <input type="checkbox"/> Check if address is new. Street:			City	State	ZIP code	Date of Birth (mm/dd/yyyy)
Home phone ( )	Email Address		<input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Marriage or Partnership (mm/dd/yyyy)		<input type="checkbox"/> Divorced
Mobile phone ( )			<input type="checkbox"/> Domestic Partner			<input type="checkbox"/> Widowed
Employer	Store #	Work Phone ( )	Date of Hire (mm/dd/yyyy)	Job Title	Union Local	
Are you covered under another other group medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," you must provide the information below.						
Name of Other Plan		Name of Primary Insured Person			Name of Employer/Plan Sponsor	
Are you covered under Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No						

### 2. ELIGIBLE CHILDREN INFORMATION (FOR CHILDREN AGES 19 UP TO AGE 26)

2A. Last Name		First Name		Mid. Initial	Social Security Number	
Mailing Address (if different from Participant) Street:			City	State	ZIP code	Date of Birth (mm/dd/yyyy)
Home phone ( )	Email Address		<input type="checkbox"/> Son	<input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Marriage or Partnership (mm/dd/yyyy)	
Work phone ( )			<input type="checkbox"/> Daughter	<input type="checkbox"/> Domestic Partner		
Employer	Employer's Address Street:		City	State	ZIP Code	
Is other coverage available to this child under another group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the name of the other insurance company/plan?						
Is this child covered under Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes to either question, please provide a copy of Medicare Card)						
2B. Last Name		First Name		Mid. Initial	Social Security Number	
Mailing Address (if different from Participant) Street:			City	State	ZIP code	Date of Birth (mm/dd/yyyy)
Home phone ( )	Email Address		<input type="checkbox"/> Son	<input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Marriage or Partnership (mm/dd/yyyy)	
Work phone ( )			<input type="checkbox"/> Daughter	<input type="checkbox"/> Domestic Partner		
Employer	Employer's Address Street:		City	State	ZIP Code	
Is other coverage available to this child under another group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the name of the other insurance company/plan?						
Is this child covered under Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes to either question, please provide a copy of Medicare Card)						
If you are enrolling more than two eligible children, print the information requested above for each child on a separate sheet of paper. Print your name and Social Security Number on the top of the page and attach it to this form.						

### 3. AUTHORIZATION AND VERIFICATION

I hereby elect coverage for my eligible child(ren) as indicated on this form and certify that the information provided on this form is complete and correct. To the extent consistent with applicable law, I hereby authorize any medical or dental provider or other health care practitioner, hospital or other institution to furnish to the Southern California Drug Benefit Fund any information required to process claims for me and my covered family members. I also authorize the Fund, its agents, designees, and representatives to disclose to any medical or dental provider, any medical or dental information required to process any claim. I understand that any dispute or controversy which may arise under the agreement between me (and/or any family member enrolled hereunder) and any HMO or Prepaid Dental Plan office must be submitted to binding arbitration in lieu of a jury or court trial. I understand that completing this form does not guarantee eligibility for benefits, and that I must first establish eligibility and maintain eligibility for benefits in accordance with the rules of the Plan. I further understand that I must notify the Drug Fund office in writing when I, or my dependent(s), obtain other coverage including Medicare.

Participant's Signature

Date

# Enrollment Form Instructions

## General

1. **DO NOT COMPLETE THIS FORM** unless you are **adding a newly eligible child** age 19 through 25 to your health care coverage under the Gold, Platinum or Platinum Plus plans.
2. Please print. Use black or blue ink only.
3. Supply all of the information requested on the form.
4. Sign, date, and mail your form and any required documentation to the Drug Fund Office. Make copies for your records before submitting the originals to the Fund Office.

## Section 1. Participant Information

Complete the entire section. Indicate whether you have additional health coverage under the Fund or from another employer, including a spouse/domestic partner's employer or Medicare.

## Section 2. Eligible Children Information

List all children, from age 19 through age 25, that you wish to enroll who do not currently have coverage under the Drug Fund (or who are currently on COBRA).

If you are enrolled in the UnitedHealthcare (UHC) Flex HMO, UHC will enroll your newly added child into the same network and Primary Care Physician as you. You can change PCP's by contacting UHC directly.

If you are enrolling more than two children, print the requested information for each additional child on a separate sheet of paper. Print your name and Social Security Number on the top of the page and attach it to this form.

Your child(ren)'s coverage will end the last day of the month in which they reach age 26, unless eligibility terminates earlier.

## Section 3. Authorization And Verification

Please read this section carefully. Sign it and date where indicated.

## Documents Required for Enrolling Children

You must supply the required documents listed below when you add a natural or adopted child, stepchild, or child of a domestic partner. If you have already supplied a document, you do not need to supply it again. If you have any questions about this requirement or need help regarding these documents, please call the Fund Office at any of the phone numbers listed below.

### To Enroll a Child

- Return this Enrollment Form along with a photocopy of the following documentation:
  - The child's birth certificate or adoption decree certified by the County Recorder
  - Adoption placement forms for a child who has been placed for adoption
  - For stepchildren/children of a domestic partner – your marriage certificate/certificate of registration of domestic partnership and the child's birth certificate

## The Administrative Office of the Fund

Street Address – 2220 Hyperion Avenue, Los Angeles, CA 90027

Mailing Address – P.O. Box 27920, Los Angeles, CA 90027-0920

Phone Numbers – 323.666.8910, 877.999.8329, extension 501 for both numbers

**If you have any questions or need help, please call the Drug Fund Office or your Union Local.**