Sheet Metal Workers' Health Plan of Southern California, Arizona & Nevada
P.O. Box 10067, Manhattan Beach, CA 90266-8567
(800) 947-4338 or (310) 798-6572
Attn: Eligibility Dept.

Participant Data Form

Please Review, Complete (print) and Sign and Date both sides of this Form.
Incomplete forms will be returned to you, and may result in a delay of benefits.

☐ New Member ☐ Add / Delete Dependent ☐ Change Address ☐ Change Beneficiary

Name:		Date of Birth:	Social Security Number:
Street Address:			Local Union #
City, State, Zip			Phone #:
Employer		Hire Date	Classification:
☐ Male ☐ Female	☐ Single	☐ Married	☐ Divorced
Spouse's Employer & City		Spouse's Insurance Co.& City	

List Below all Eligible Dependents (including spouse, if married)
If adding or deleting a dependent, you must submit copies of legal proof of relationship with this form.

Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship

Death Benefit Beneficiary (Under the Health Plan)

Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship
Complete Address:					

✍ ______________________________ ______________________________

Signature ***Date***

* Important *

Newly acquired eligible dependents must be enrolled within 31 days from the date dependency status is met. Otherwise, the dependent's coverage effective date may be delayed until the first of the month following the date the Administrative Office received the required documentation.

You must IMMEDIATELY notify the Administrative Office, in writing, when dependent status changes occur. This includes final dissolution of marriage, death, a former full-time student over age 19 not taking enough units at school, marriage of a child, and any other events which would make your dependent not eligible for further coverage.

If claims and/or premiums are paid for any dependent spouse or child and it is later found that the dependent was not eligible, you and/or the dependent are responsible for reimbursing the Plan for any benefits and/or premiums paid, plus interest, and any costs and attorney's fees if a lawsuit must be filed to recover any benefits overpaid.

Dependents who no longer meet the rules of the Plan may be entitled to continue coverage on a self-pay basis, in accordance with the rules and regulations of COBRA. Please refer to the Summary Plan Description for complete details.

Copies of the following documentation must be included with this Form in order to add or delete a dependent

Spouse a copy of your Marriage Certificate

Children a copy of their Birth Certificate and/or Court Orders. For newborns, please submit a copy of the hospital's *Verification* or *Certification of Birth* as soon as possible.

Students (age 19 through 23) verification of full-time student status (at least 12 units per semester). This information is required every February and every September

Ex-spouse a copy of your divorce decree

Enclosed are copies of all necessary documents. I hereby certify that the foregoing statements, including any accompanying statements and documents are true, correct, and complete to the best of my knowledge. I understand that incomplete Data Forms will be returned to me, and eligibility for benefits on dependents will not be verified until the proper documents are received in the Administrative Office.

Signature ***Date***