

Professional Musicians Local 47 Health and Welfare Enrollment Change Form

Section A				EMPLOYEE INFORMATION		<input type="checkbox"/> NEW ADDRESS	
Last Name	First Name	Middle Int.	Birth Date	Social Security No.			
Address			Home Phone		Business Phone		
City		State		Zip Code			
PRIMARY CARE PHYSICIAN NAME				Existing Patient Y / N		PHYSICIANS #::	
						MEDICAL GRP #::	

DELTA CARE PROVIDER # :

Section B						PLEASE SELECT ENROLLMENT CHANGE									
<input type="checkbox"/> Member			<input type="checkbox"/> Member + One			<input type="checkbox"/> Member +Family									
<input type="checkbox"/> Option #1		Health Net – HMO		<input type="checkbox"/> Option #2		Health Net - HMO DeltaCare (DHMO) & MES Vision		<input type="checkbox"/> Option #3		Health Net– HMO Delta Preferred (PPO) & MES Vision					
<input type="checkbox"/> Option #4		Health Net – PPO		<input type="checkbox"/> Option #5		Health Net – PPO DeltaCare (DHMO) & MES Vision		<input type="checkbox"/> Option #6		Health Net – PPO Delta Preferred (PPO) & MES Vision					

Section C								LIST DEPENDENT CHANGES							
Last Name	First Name	Date of Birth	Social Security Number	M or F	Physician #	Physician Name	Medical Grp #								
<input type="checkbox"/> Add <input type="checkbox"/> Delete - Spouse															
<input type="checkbox"/> Add <input type="checkbox"/> Delete - Dependent															
<input type="checkbox"/> Add <input type="checkbox"/> Delete - Dependent															
<input type="checkbox"/> Add <input type="checkbox"/> Delete - Dependent															

Section D PLEASE READ CAREFULLY AND SIGN BELOW

I APPLY FOR BENEFITS FOR THE PERSONS LISTED AND I AGREE THAT MY FAMILY AND I SHALL ABIDE BY THE PROVISIONS OF SERVICE AGREEMENTS UNDER WHICH WE ARE ENROLLED.

I understand that misrepresentations in answering questions on this application or non-payment of premium may result in cancellation of membership. All benefits and exclusions are set forth in the Service Agreement of the Health or dental Plan. I understand that it is my responsibility to report to the Administrator any change in eligibility of my dependents. I agree to abide by the provisions as outlined.

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION: I authorize any “provider of care”, insurer or health plan to disclose to the Health/Dental Plan (s) or their representatives all “medical information” (as those terms are defined in the California Civil Code), including any medical information regarding substance abuse or mental or emotional conditions, regarding me, my spouse, or my children. This medical review information is collected for the purpose of evaluating my employer’s application, determining claims for benefits, or for quality assurance and peer review. This Authorization will remain valid for the term of coverage of the health/dental service contract. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

Signature of Applicant **X** _____ Date _____

TO BE COMPLETED BY ADMINISTRATOR			
Amount Paid \$	Check #	Unit No. 3000-	Effective Date Of Coverage