



**LABORERS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA**  
**LABORERS VACATION-HOLIDAY TRUST FUND FOR NORTHERN CALIFORNIA**  
**LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNIA**  
**LABORERS ANNUITY PLAN FOR NORTHERN CALIFORNIA**  
 220 Campus Lane, Fairfield, CA 94534-1498 \* Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530  
 E-Mail Address: customerservice@norcalaborers.org \* Website: http://www.norcalaborers.org

## ENROLLMENT FORM

### Part I. PARTICIPANT INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST			MIDDLE	LAST
MAILING ADDRESS		CITY		STATE	ZIP CODE
TELEPHONE NO.	E-MAIL ADDRESS, IF ANY	LOCAL UNION NO.	<input type="checkbox"/> <i>Quando posible prefiero recibir información de beneficios en Español.</i>		
DATE OF BIRTH	MONTH / DAY / YEAR	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED – Give date of marriage:	MONTH / DAY / YEAR	

### Part II. DEPENDENT INFORMATION

**IMPORTANT:** List all “Eligible Dependents” to be enrolled in the Health and Welfare Plan. The term “Eligible Dependents” means your legal spouse, your children under age 26 regardless of marital status, and your unmarried children 26 of age or older who are totally handicapped as explained in the Plan. Unless documents have been previously provided, you are required to mail the applicable document(s) below to the Fund Office to substantiate your relationship to your dependent(s):

**SPOUSE** – Marriage Certificate

**NATURAL CHILD** – Birth Certificate

**ADOPTED CHILD** – Birth Certificate and Legal adoption document

**STEP-CHILD** – Birth Certificate (An Affidavit for Stepchild Coverage form will be mailed to you for determination of eligibility)

**LEGAL GUARDIANSHIP** – Guardianship papers or documents from a Court appointing you as the legal guardian

**Write your social security number on each of the document(s) for identification purposes.** Please notify or contact the Fund Office if documents are not available.

For **Domestic Partner** enrollment information, please read the reverse side for information and documents required.

NAME - WRITE FIRST & MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM YOURS)	DATE OF BIRTH MONTH / DAY / YEAR	SOCIAL SECURITY NUMBER	DEPENDENT RELATIONSHIP
1.			<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER
2.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
3.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
4.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
5.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER

**This form will be returned if you fail to provide the dependent’s date of birth and Social Security number.**

### Part III. BENEFICIARY INFORMATION - DESIGNATION OF BENEFICIARY

1. **Health and Welfare and Vacation-Holiday Trust Funds** – You may designate any beneficiary you wish. Any benefits due from these Funds will be paid to your named beneficiary.
2. **Pension Trust Fund and Annuity Plan** - If you are married, any benefits due will be paid to your surviving spouse, and not to your named beneficiary if not your spouse, in accordance with the provisions of the Pension and Annuity Plans. Contact the Fund Office or refer to your Plan booklets for more information regarding payment of benefits to beneficiary.

If you want to designate more than one person for one or more of the Funds, do not complete this section. Check-off this box  to receive the appropriate form needed.

SOCIAL SECURITY NUMBER	NAME: FIRST			MIDDLE	LAST	RELATIONSHIP
MAILING ADDRESS		CITY		STATE	ZIP CODE	

## Part IV. OTHER INSURANCE INFORMATION

Do any of your dependents listed on the reverse side of this form have another employer sponsored medical, prescription drug, dental and/or vision Plan coverage either as an employee or as a dependent?  No  Yes  
 If you answered "No", skip section IV. If you answered "Yes", fill in section IV. If you have more than one dependent who has another employer sponsored Plan, make a photocopy of section IV and complete the section for each dependent.

Name of Insured or policy holder		Relationship to Participant	
Social Security Number or ID number of Insured		Name of employer providing the coverage	
TYPE OF BENEFITS PROVIDED	POLICY NUMBER	EFFECTIVE DATE	DEPENDENTS COVERED?
NAME & ADDRESS OF MEDICAL PLAN			<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME & ADDRESS OF DENTAL PLAN			<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME & ADDRESS OF PRESCRIPTION DRUG PLAN			<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME & ADDRESS OF VISION CARE PLAN			<input type="checkbox"/> YES <input type="checkbox"/> NO

## Part V. DOMESTIC PARTNER INFORMATION

In order to determine whether your Domestic Partner meets the Plan's requirement for Domestic Partner coverage, please furnish the information below. To enroll your Domestic Partner's children, if any, you must provide the applicable documents as listed in the Dependent Information section of this form.

A written statement from your employer certifying that the employer has a job contract with the City or County of San Francisco, City of Oakland, City of Sacramento, County of San Mateo or the State of California. If the employer has entered into a contract with the State of California, they must also certify that the cumulative amount of the contract is \$100,000.00 or more during the State's fiscal year.

If your employer certifies that they are doing business with or have entered into a job contract with the City or County of San Francisco, City of Oakland or City of Sacramento, you must provide a copy of your Domestic Partner certificate issued by any city, county or state agency or,

If your employer certifies that they are doing business with or have entered into a job contract with the **County of San Mateo or the State of California**, you and your partner must be registered as domestic partners with the California **Secretary of State**, obtain a domestic partners certificate from the Secretary of State's office and provide a copy to the Fund office. Please be aware that the recently enacted Assembly Bill 17 applies to **County of San Mateo and the State of California**. AB 17 requires employers to provide benefits to **same-sex** partners only. There is an exception for opposite sex partners if either you are or your partner is over age 62.

## PARTICIPANT STATEMENT – You MUST date and sign form

*I hereby certify under penalty of perjury under the laws of the State of California that the information given in this form is true, correct and complete to the best of my knowledge.*

DATE:

SIGNATURE: