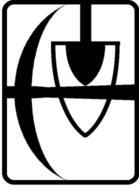

LABORERS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA
220 Campus Lane, Fairfield, CA 94534-1498
Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530
E-Mail Address: customerservice@norcalaborers.org
Website: http://www.norcalaborers.org

FUND OFFICE USE ONLY (610)
EFF. DATE:
HCID: LA
ELIGIBILITY CODE/GROUP NO.: /

RETIRED PLAN DENTAL ENROLLMENT FORM

RETIREE INFORMATION (Please print or type in black ink only)

SOCIAL SECURITY NUMBER	NAME: FIRST	MIDDLE	LAST

RESIDENCE ADDRESS (not Post Office Box)	CITY	STATE	ZIP CODE

TELEPHONE NO.	LOCAL UNION	DATE OF BIRTH			GENDER	MARITAL STATUS
		MONTH	DAY	YEAR	☐ MALE	☐ SINGLE
( )					☐ FEMALE	☐ MARRIED

DENTAL PLAN OPTIONS

IMPORTANT: You and your Dependents must be enrolled in the same Dental Plan. Check only one box.

☐ **Delta Dental.** You may seek dental care from any dentist but, your out-of-pocket expense is lower if you use a participating Delta Dental dentist.

☐ **Delta Care USA**.
You must select a Dental Office from Delta Care Participating Dental Offices Directory – see enclosed directory:

Name of Dental Office: ______________________________ Facility No.: ____________

DEPENDENT INFORMATION (List all eligible dependents to be enrolled. Use back page if more space needed.)

FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM EMPLOYEE)	DATE OF BIRTH MO / DY / YR	DEPENDENT RELATIONSHIP	FUND OFFICE USE ONLY
1.		SPOUSE	
2.		☐SON ☐DAUGHTER	☐STUDENT
3.		☐SON ☐DAUGHTER	☐STUDENT

I understand that once I have selected a Dental Plan, I can only change to another Dental Plan during the Fund's open enrollment which is every March 1. I agree to be bound by the benefits, deductions, co-payments, exclusions and other terms of the Plan group agreement.

Important: Your application will not be accepted without your signature below. Please return this Enrollment Form to the Fund Office. If you enroll in Delta Care USA, any dispute that may arise between you and the Dental Plan will be subject to binding arbitration.

Date:____________________Retiree's Signature:____

FUND OFFICE USE ONLY (Please do not write in this space)

☐ NEW RETIREE ☐ OPEN ENROLLMENT ☐ COBRA - DATE OF QUALIFYING EVENT__________	REMARKS: DATE:__________BY:__________

Revised 1/22/2009