



**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.:

**ACTIVE PLANS DENTAL ENROLLMENT FORM**

**EMPLOYEE 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	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> 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:  
Name of Dental Office: \_\_\_\_\_ Facility No.: \_\_\_\_\_
- Bright Now!/Newport Dental.** You may seek dental care from any Bright Now! Office Locations.
- Pacific Union Dental.** You must select a dentist or dental group from Pacific Union Dental Provider Directory:  
Name of Dentist: \_\_\_\_\_ Dentist 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	<b>FUND OFFICE USE ONLY</b>
1.		SPOUSE	
2.		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
3.		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
4.		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
5.		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT

*I understand that once I have selected a Plan, I cannot change to another Plan until the next Open Enrollment. I agree to be bound by the benefits, deductions, co-payments, exclusions and other terms of the Plan group agreement. Your application will not be accepted without your signature below. Please return this Enrollment Form to the Fund Office.*

**Important: If you enroll in Delta Care USA, Bright Now!/Newport Dental or Pacific Union Dental, any dispute that may arise between you and the Dental Plan will be subject to binding arbitration.**

Date: \_\_\_\_\_ Employee's Signature: \_\_\_\_\_

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

<input type="checkbox"/> NEW EMPLOYEE <input type="checkbox"/> OPEN ENROLLMENT	REMARKS:
<input type="checkbox"/> COBRA - DATE OF QUALIFYING EVENT _____	DATE: _____ BY: _____