NORTHERN CALIFORNIA GENERAL TEAMSTERS SECURITY FUND

CHANGE REQUEST FORM

P.O. BOX 1147, STOCKTON, CA 95201-1147
Phone: (800) 417-8923 | Fax: (209) 474-5402

DELTA HEALTH SYSTEMS

HEALTHCARE IDENTIFICATION NUMBER

			-					

SOCIAL SECURITY NUMBER

			-			-				

☐ CHECK IF SSN CORRECTION

Employee's Last Name | First Name | MI | Former Name if Name Change or Correction

Address – House # & Street Name or PO Box

☐ CHECK IF NEW ADDRESS

City, State, Zip Code

/ / Date of Birth (Mo/Day/Yr)

☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Daytime Phone Number | Home Phone Number | Employee's Email Address

Employer Name

/ / Effective Date (Mo/Day/Yr)

Change of Life Insurance Beneficiary

Relationship

HEALTH PLAN COVERAGE (please select one)

☐ PPO Medical / Rx / Dental / VSP / Life

☐ Kaiser Medical / Rx / Vision and Dental / Life
I understand I must work or reside within a Northern California Kaiser service area to elect Kaiser coverage and must also complete the Kaiser Subscriber Enrollment/Change form.

DENTAL PLAN COVERAGE (please select one)

☐ PPO DENTAL PLAN

☐ ANTHEM DENTAL DHMO. All dental care must be provided by one of the Anthem Dental DHMO Dental providers.

☐ NEWPORT DENTAL DHMO. All dental care must be provided by one of the Newport Dental DHMO Dental providers.

CHANGE REQUEST FORM

TO ADD OR REMOVE DEPENDENTS, FILL IN THE INFORMATION BELOW. You must attach a county-recorded marriage and/or birth certificate for each newly enrolled dependent.

Please Check One	Last Name, First Name, MI	Relation	Date of Birth (Mo/Day/Yr)	Date of Qualifying Event Marriage/Adoption/ Domestic Partnership/ Divorce/Death	If dependent has other health insurance, indicate carrier name and ID #
☐ Add ☐ Remove			/ /	/ /	
SSN:	- -				
☐ Add ☐ Remove			/ /	/ /	
SSN:	- -				
☐ Add ☐ Remove			/ /	/ /	
SSN:	- -				
☐ Add ☐ Remove			/ /	/ /	
SSN:	- -				
☐ Add ☐ Remove			/ /	/ /	
SSN:	- -				
☐ Add ☐ Remove			/ /	/ /	
SSN:	- -				

EMPLOYEE SIGNATURE AND CONSENT

I understand that I cannot change/revoke this election during the plan year unless I experience a change in family status (i.e. marriage/divorce, birth/adoption of a child, death of a family member, involuntary termination of a spouse's employment), or move out of the Northern California Kaiser or Anthem Dental DHMO/Newport Dental DHMO service area. I understand that this election will continue in effect until modified by a subsequent election.

I understand that The Northern California General Teamsters Security Fund ["Health Plan"] may use my health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. I understand that the Health Plan has established a policy to guard against unnecessary disclosure of my health information.

I authorize all health care providers, claim processing agents, insurance and reinsurance agencies or other persons or organizations performing direct administrative, professional, medical, or legal services in connection with me or my covered dependents to disclose any information necessary for investigation, evaluation, or payment of a claim.

I certify that all information contained herein is true and correct.

Employee Signature _____ Date _____