District Council 1707, Local 95
Head Start Employees Welfare Fund

Employer: Complete Section A
Employee: Complete Section B-D

ENROLLMENT/CHANGE FORM

(PLEASE PRINT)

ACCOUNT INFORMATION

A

☐ Open Enroll ☐ Change ☐ New Enroll ☐ Reinstate	Effective Date: (MM/DD/CCYY)	Employer Name:	Employer Address:

Acct. No.:	Plan:	Date of Hire: (MM/DD/CCYY)		Agency:	Medical Benefit Option: ☐ Single ☐ Family

Type of Change:		☐ Address Change	☐ Family Security Benefit/Surviving Spouse
☐ Add Dependent(s)*	Date:	☐ Retirement	☐ Transfer to COBRA: ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
☐ Cancel Employee	Last Date of Coverage:	☐ Other:	
☐ Cancel Dependents(s)*	Last Date of Coverage:	*List Names in Section B.	

PERSONAL INFORMATION

B

Employee Name (Last, First, M.I.):	Social Security No.:

Employee Date of Birth: (MM/DD/CCYY)	Home Phone:	Work Phone:	Home Email:	Employee I.D.:

Street Address:	City:	State:	Zip:

I would like coverage for me and my dependents: (Last, First, M.I.)	Dependent Social Security No.	Date of Birth	Gender
Employee:			☐ M ☐ F
Spouse*:			☐ M ☐ F
Dependent*:			☐ M ☐ F
Dependent*:			☐ M ☐ F
Dependent*:			☐ M ☐ F

* Spouse and /or Dependent – Please attach proof of eligibility. List of acceptable documents available in Human Resources.

OTHER HEALTH CARE COVERAGE

C

Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No If yes, please provide the following information on the next lines:

	Name of Person Covered	Social Security No.	Effective Date	Medicare: Part A	Part B	Medicaid	Other Insurance Carrier
1				☐	☐	☐	☐
2				☐	☐	☐	☐

SIGNATURE

D

Signature – The information provided above is true and correct to the best of my knowledge.

Employee's Signature/Date:	Spouse's Signature/Date:	Employer's Signature/Date:

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