Southern California IBEW-NECA Health Trust Fund
6023 Garfield Avenue
City of Commerce, California 90040
Mailing Address: P.O. Box 910918, Los Angeles, CA 90091
(323) 221-5861 or (800) 824-6935 (Nationwide)

ACTIVE
HEALTH AND DENTAL PLAN
FAMILY ACCOUNT CHANGE FORM
www.scibew-neca.org
Fax No. (323) 726-3520

PARTICIPANT INFORMATION	Social Security Number				-			-				

Last Name	First Name	MI

Street Address – **Do *NOT* use P.O. Box**	Apt. No.	City

State	Zip Code	Phone ( )	Birthdate

Is there a language, other than English, that is your language of choice?:	No ☐	Yes ☐ Language: _____	Decline to respond ☐
For your spouse, is there a language, other than English, that is the language of choice?:	No ☐	Yes ☐ Language: _____	Decline to respond ☐

Signature	Date

FAMILY MEMBER ADD/DROP

(for a drop, must also complete Sections A & B below)

ADD	DROP	Relationship (Check Box)	Last Name	First Name	MI	Date of Birth	Social Security Number	FOR UNITEDHEALTHCARE ONLY Primary Care Physician/Code
☐	☐	☐ Spouse - Female ☐ Spouse - Male						
☐	☐	☐ Son ☐ Daughter						
☐	☐	☐ Son ☐ Daughter						
☐	☐	☐ Son ☐ Daughter						
☐	☐	☐ Son ☐ Daughter						
☐	☐	☐ Son ☐ Daughter						
☐	☐	☐ Son ☐ Daughter						

ADD: Please review this Section if adding a family member	
If adding a….	**Required documents to submit with this form**
Spouse	Copy of Marriage Certificate
Dependent child up to age 26	Copy of birth certificate or adoption papers

DROP: Please review this Section if dropping a family member	
If dropping a….	**Required documents to submit with this form**
Spouse	Copy of final Divorce Decree

Please complete Sections A & B below and attach required documents

Has the dependent listed above ever been a member of this Health Plan? Yes☐ No☐

Complete Sections A and B if dropping a Family Member, and include any required documentation along with this form.

SECTION A – If you are dropping a family member, place a check by the appropriate reasons.

☐ A divorced or legally separated spouse, effective date ____/____/_____.

☐ Child no longer qualifies as a dependent, effective date ____/____/_____.

☐ Other _____, effective date ____/____/_____.

SECTION B – Please provide current information of dependent(s) being dropped (attach additional page if more space is required)

Name		
Address		
City	State	Zip Code

For name change, must attach notice that Social Security will use new name for their records.

NAME CHANGE

****PLEASE ALSO COMPLETE PARTICIPANT INFORMATION ABOVE****

☐ MY NAME ONLY ☐ ENTIRE FAMILY	Former Last Name	First Name	MI

FOR OFFICE USE ONLY

Medical Group Number	Dental Group Number	Effective Date of Change Month	Day	Year	Document received with Form – Initials _____ Date _____ ☐ Marriage Certificate ☐ Adoption papers ☐ Divorce Decree ☐ Birth Certificate ☐ Social Security name change ☐ Death Certificate