1199SEIU Benefit Funds

330 West 42nd Street, New York, NY 10036-6977 • www.1199SEIUBenefits.org
Tel (646) 473-9200 • Outside NYC Area Codes: (800) 575-7771

GHI Dental Enrollment Form

Benefits are subject to each Fund's Summary Plan Description (SPD) and the discretion of that Fund.
This Form is Strictly Confidential. You Must Answer All the Questions. Please Print Clearly in Black or Blue

Check One:
Marque una

☐ I am enrolling in the GHI Preferred Plus Program.
Me estoy inscribiendo en el Programa GHI Preferred Plus.

☐ I am enrolling in the dental program of my 1199SEIU Benefit Fund.
Me estoy inscribiendo en el programa dental de mi Fondo de Beneficios de 1199SEIU.

☐ This is a change from my current Dental Program.
Éste es un cambio de mi programa dental actual.

Member ID: _____ Member's Full Name: _____
ID del Miembro Nombre Completo del Miembro

Address: _____ City: _____ State: _____ Zip Code: _____
Domicilo Ciudad Estado Zona Postal

Telephone: (_____) _____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F
Telefono Fecha de Nacimiento Month Day Year Sexo

Name of Employer: _____ Date of Hire: _____/_____/_____
Nombre de su Patrono Fecha de Empleo Month Day Year

Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Estado Civil Actual Solo Casado Divorciado Enviudado

Please Print Clearly in Black or Blue Ink	Date of Birth Fecha de Nacimiento MM/DD/YYYY
Member's Full Name Nombre Completo del Miembro	_____/_____/_____
Spouse's/Same Sex Domestic Partner's Full Name Nombre Completo del Cóyuge/Pareja Doméstica del Mismo Sexo	_____/_____/_____
1 Child's Full Name Nombre Completo del Hijo(a)	_____/_____/_____
2 Child's Full Name Nombre Completo del Hijo(a)	_____/_____/_____
3 Child's Full Name Nombre Completo del Hijo(a)	_____/_____/_____
4 Child's Full Name Nombre Completo del Hijo(a)	_____/_____/_____
5 Child's Full Name Nombre Completo del Hijo(a)	_____/_____/_____

Required Information

Does your spouse and/or dependent children have other health insurance coverage? ☐ Yes ☐ No
¿Hace a su esposo y/o niños dependientes tienen otra forma de seguro médico? Sí No

If yes, name of insurance company/plan: _____
Sí "Sí," el nombre de compañís de seguros o planea.

Policyholder: _____ Group Number: _____
Dueño de póliza Numero de grupo

Type of Coverage: ☐ Medical ☐ Hospital ☐ Rx ☐ Dental
Tipo de Beneficios Medicos Hospital Recetas Dentales

I hereby request participation in the 1199SEIU Benefit Funds Dental Program written above. I understand that I and my eligible family members must enroll in the same program. I also authorize, to the Benefit Funds, the release of all medical/dental information necessary for the processing of any and all medical/dental claims. Coverage is based on eligibility in the 1199SEIU National Benefit Fund or the 1199SEIU Greater New York Benefit Fund.

Por el presente solicito participar en el programa dental del Fondo de Beneficios de 1199SEIU escrito arriba. Entiendo que yo y los miembros de mi familia elegibles debemos inscribirnos en el mismo programa. También autorizo al Fondo de Beneficios a divulgar toda la información médica/dental necesaria para procesar cualquiera y todos los reclamos médicos/dentales. La cobertura se basa en la elegibilidad para el Fondo Nacional de Beneficios de 1199SEIU o el Fondo de Beneficios de la 1199SEIU del Gran Nueva York.

Member's Signature **X** _____ Date: _____
Firma de Miembro Fecha

The National Benefit Fund believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for an external review process for claims appeals. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding the Fund's status as a grandfathered health plan can be directed to the Fund at (646) 473-9200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please complete this form and mail to:
1199SEIU Benefit and Pension Funds
Member Eligibility Department
PO Box 1035
New York, NY 10108-1035