CWA LOCAL 1181 SECURITY BENEFIT FUND

ENROLLMENT CHANGE FORM

PLEASE COMPLETE AND RETURN TO

Administrative Services Only, Inc
303 Merrick Road, Suite 300
Lynbrook, NY 11563
1.800.537.1238

PLEASE INDICATE REASON(S) FOR SUBMISSION AND COMPLETE THE APPROPIATE SECTION(S):

☐ ADD SPOUSE	☐ ADD DEPENDENT(S) CHILD	☐ CHANGE ADDRESS	☐ NAME CHANGE
☐ DELETE SPOUSE	☐ DELETE DEPENDENT CHILD	☐ TERMINATION OR ADDITION OF OTHER COVERAGE	☐ OTHER CHANGE

SECTION I MEMBER INFORMATION

LAST 4 DIGITS OF SOCIAL SECURITY NO		DATE OF BIRTH MM-DD-YYYY		
MEMBER LAST NAME	FIRST NAME	MI		
ADDRESS	APT NO.	CITY	STATE	ZIP
PERSONAL EMAIL ADDRESS:				
PHONE: HOME		CELL		

SECTION II CHANGE OF ADDRESS: Please indicate new address below

ADDRESS	APT NO.	CITY	STATE	ZIP

SECTION III ADD DEPENDENT CHILD INFORMATION-(DEPENDENT CHILDREN UP TO AGE 26) COPIES OF BIRTH CERTIFICATES, ADOPTION CERTIFICATES, PROOF OF LEGAL GUARDIANSHIP MUST BE ATTACHED.

FIRST NAME	LAST NAME	DATE OF BIRTH (MM-DD-YYYY)	GENDER	SOCIAL SECURITY NO.
			☐ MALE ☐ FEMALE	
			☐ MALE ☐ FEMALE	
			☐ MALE ☐ FEMALE	

SECTION IV **ADD SPOUSE/DOMESTIC PARTNER-**

PLEASE ATTACH COPY OF MARRIAGE CERTIFICATE/DOMESTIC PARTNER FORM

DELETE SPOUSE/DOMESTIC PARTNER - DUE TO:

☐ **DEATH** **DATE:**_____ **PLEASE ATTACH DEATH CERTIFICATE**

☐ **DIVORCE** **DATE:**_____ **PLEASE ATTACH DIVORCE DECREE**

SPOUSE/DOMESTIC PARTNER SOCIAL SECURITY NUMBER	DATE OF BIRTH MM-DD-YYYY

SPOUSE FIRST NAME	LAST NAME	MI	EMAIL ADDRESS

IS SPOUSE EMPLOYED? ☐ YES ☐ NO

IF YES, EMPLOYER NAME:_____ PHONE NO _____

PLEASE INDICATE IF SPOUSE IS COVERED UNDER A:		IF YES, PLEASE PROVIDE NAME INSURANCE COMPANY/BENEFIT ADMINISTRATOR
DENTAL PLAN	☐ YES ☐ NO	
OPTICAL PLAN	☐ YES ☐ NO	
PRESCRIPTION DRUG PLAN	☐ YES ☐ NO	

SECTION V **NAME CHANGE:** Please attach copy of social security card or court order indicating new name

LAST NAME TO _____ FROM_____

FIRST NAME TO_____ FROM_____

SECTION VI ☐ **ADDITION OF OTHER COVERAGE:** Policy Holder Name:_____ Effective Date:_____

☐ **TERMINATION OF OTHER COVERAGE:** Please attach letter from Employer or Insurance Company indicating the type of coverage being terminated and the effective date of termination

PLEASE INDICATE COVERAGE BEING ADDED OR TERMINATED	PLEASE PROVIDE NAME INSURANCE COMPANY/BENEFIT ADMINISTRATOR
☐ DENTAL PLAN	
☐ OPTICAL PLAN	
☐ PRESCRIPTION DRUG PLAN	

SECTION VII **OTHER CHANGE:** Please indicate requested change and provide supporting documentation.

SECTION VIII **MEMBER SIGNATURE:**

I HEREBY CERTIFY THAT ALL THE INFORMATION PROVIDED IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A DENIAL OR SUSPENSION OF BENEFITS. IN ADDITION, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR THE FUND OR FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF PROVIDING MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

MEMBER'S SIGNATURE:_____ **DATE:**_____