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

Member Choice 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

You do not have to enroll again if you are already enrolled in a Member Choice Program.
No tiene que inscribirse de Nuevo si ya es miembro de un Programa de Member Choice.

Check one:
Marque una

☑

- ☐ I am enrolling in a Member Choice Program for the first time.
  Me inscribo en un Programa de Member Choice por prima vez.
- ☐ I am changing enrollment from one Member Choice Hospital to another.
  Me cambio de un Hospital de Member Choice a otro.
- ☐ I am changing from one Primary Care Doctor to another.
  Me cambio de un Medico de Cuido Primario a otro.

Member ID or Social Security #: _____ Member's Full Name: _____
ID del Miembro o Seguridad Social — 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

Print your choice of Member Choice Hospital and Primary Care Doctor next to your name and the name of each eligible family member below. Abajo, escriba su preferencia de Programa y de Médico al lado de su nombre ye el nombre de cada familiar elegible.

Please Print Clearly in Black or Blue Ink	Date of Birth Fecha de Nacimiento MM/DD/YYYY	Member Choice Hospital Hospital	Primary Care Doctor Dr. de Cuidado Primario
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 — Hopspital — Recetas — Dentales

I hereby request participation in the 1199SEIU Benefit Funds' Member Choice Program written above. I understand that I must choose a Member Choice Network and Primary Care Doctor for each person enrolled. I also authorize the release to the Benefit Funds of all medical information necessary for the processing of any and all medical claims.
Por el presente solicito participar en el programa Member Choice del Fondo de Beneficios de 1199SEIU escrito arriba. Entiendo que debo elegir una red y un médico de atención primaria de Member Choice para cada persona inscrita. También autorizo la divulgación a los Fondos de Beneficios de toda la información médica necesaria para procesar cualquiera y todos los reclamos médicos.

Member's Signature **X** _____ Date: _____
Firma del 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 Funds
Member Choice Enrollment
PO Box 1033
New York, NY 10108-1033

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