



ADD/DELETE DEPENDENTS FORM

NORTHERN CALIFORNIA TILE INDUSTRY HEALTH & WELFARE FUND

P.O. Box 2500
San Francisco, CA 94126
(415) 986-6276

THE PURPOSE OF THIS FORM IS TO ADD OR DELETE DEPENDENTS IN THE NORTHERN CALIFORNIA TILE INDUSTRY HEALTH & WELFARE PLAN. THIS INCLUDES ENROLLMENT/DIS-ENROLLMENT IN THE SELF-FUNDED MEDICAL AND DENTAL PLANS. **IF YOU ARE ENROLLED IN AN HMO, YOU MUST COMPLETE THAT HMO'S REQUIRED FORM IN ORDER TO MAKE THIS CHANGE APPLY TO YOUR HMO.**

YOUR NAME

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	
MAILING ADDRESS (STREET OR P.O. BOX)			SEX	DATE OF BIRTH
CITY	STATE/ZIP	TELEPHONE NUMBER ()		EMAIL ADDRESS

ADD/DELETE DEPENDENT SPOUSE

SPOUSE'S NAME	ADD/DELETE	EFFECTIVE DATE	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH

- To **ADD** a spouse, you must include a copy of your marriage certificate.
- To **DELETE** a spouse, you must include a copy of your divorce decree or your legal separation agreement, as appropriate.

ADD/DELETE DEPENDENT CHILD

CHILD'S NAME	ADD/DELETE	EFFECTIVE DATE	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH

- To **ADD** a child, you must include a copy of the child's birth certificate or adoption certificate, as appropriate.

I HEREBY DECLARE THAT ALL STATEMENTS AND ANSWERS ABOVE ARE TRUE, AND THAT THEY ARE THE BASIS ON WHICH COVERAGE MAY BE EXTENDED UNDER THE PLAN.

Employee Signature

Date

INTERNAL OFFICE USE ONLY