District Council 37, Local 95
Head Start Employees Welfare Fund

Employer: Complete Section A
Employee: Complete Section B-D

ENROLLMENT/CHANGE FORM

(PLEASE PRINT)

ACCOUNT INFORMATION

A

☐ Open Enroll ☐ Change ☐ New Enroll ☐ Reinstate	Effective Date: (MM/DD/CCYY)	Employer Name:	Employer Address:

Acct. No.:	JobTitle:	Date of Hire: (MM/DD/CCYY)		Agency:	Medical Benefit Option: ☐Single Family☐

Type of Change:		☐ Address Change	☐ Family Security Benefit/Surviving Spouse
☐ Add Dependent(s)*	Date:	☐ Retirement	☐ Transfer to COBRA: ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
☐ Cancel Employee	Last Date of Coverage:	☐ Other:	
☐ Cancel Dependents(s)*	Last Date of Coverage:	*List Names in Section B.	

PERSONAL INFORMATION

B

Employee Name (Last, First, M.I.):	Social Security No.:

Employee Date of Birth: (MM/DD/CCYY)	Home Phone:	Work Phone:	Home Email:	Employee I.D.:

Street Address:	City:	State: NY	Zip:

I would like coverage for me and my dependents: (Last, First, M.I.)	Dependent Social Security No.	Date of Birth	Gender
Employee:			☐ M ☐ F
Spouse*:			☐ M ☐ F
Dependent*:			☐ M ☐ F
Dependent*:			☐ M ☐ F
Dependent*:			☐ M ☐ F

* Spouse and /or Dependent – Please attach proof of eligibility. List of acceptable documents available in Human Resources.

OTHER HEALTH CARE COVERAGE

C

Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No If yes, please provide the following information on the next lines:

	Name of Person Covered	Social Security No.	Effective Date	Medicare: Part A	Part B	Medicaid	Other Insurance Carrier
1				☐	☐	☐	☐
2				☐	☐	☐	☐

SIGNATURE

D

Signature – The information provided above is true and correct to the best of my knowledge.

Employee's Signature/Date:	Spouse's Signature/Date:	Employer's Signature/Date:

DC 1707, LOCAL 95 HEAD START EMPLOYEES WELFARE FUND ENROLLMENT CARD

Please Print

Social Security Number

Last name First name Middle initial

Home address Apt. #

City State Zip Code Telephone Number

Birthdate: Month Day Year Sex: M☐ F☐ Marital Status Date of Marriage

Center Name Job Title

Date Employed: Month Day Year Employee Signature Date

WELFARE FUND USE ONLY

Cen. Code

Rate Level

Title

Level

Effective Date

Leave Date

Leave Type

Return

Effective Date

LIST BELOW NAME(S) OF SPOUSE AND ALL UNMARRIED DEPENDENT CHILDREN UNDER 26 YEARS.

	Name	Social Security Number	Check (X) Relationship				Date of Birth		
			Wife	Hsbd.	Son	Dghtr.	Month	Day	Year
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

IMPORTANT:

In addition to this enrollment card you must submit a completed [redacted] Health Transaction Form to be enrolled for health insurance benefits.

EMPLOYER MUST COMPLETE **Agency Code #**

Does employee work Full Time? ________ # of hours per week

Does employee work Part Time? ________ # of hours per week

Date Employed/Return ________ Job Title ________

Signature Title Date

NOTE: This enrollment card is only for the purpose of enrollment into the DC 1707, Local 95 Head Start Employees Welfare Fund. Coverage will not become available until the Fund receives the completed enrollment card with the appropriate documentation.

PLEASE SIGN AND RETURN TO YOUR CENTER'S BOOKKEEPER. CENTER MUST MAIL TO:

District Council 1707, Local 95 Head Start Employees Welfare Fund

420 West 45th Street, 3rd Floor, New York, NY 10036

(212) 343-1660