



Teamsters Security Fund
for Southern Nevada
Local 14



P.O. Box 27287
Las Vegas, NV 89126-1287

Phone: (702) 851-8286
Fax: (702) 734-8619

Enrollment Form

Please print in black ink or type. Complete, sign and return this form to the address noted at left.

Check one box for each category: MEDICAL ☐ PPO Plan (Anthem BlueCross BlueShield Network) ☐ ECP (Engaged Care Plan) DENTAL ☐ Delta Dental PPO Plan ☐ Liberty Dental DHMO-EPO Plan**											
Last Name				First Name				MI	☐ Male ☐ Female		
Mailing Address			City		State	Zip	Date of Birth		Social Security #		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed			Date of Marriage		Date of Divorce		Email Address		Medicare Eligible?	Other Insurance Coverage?	
Current Employer			Hire Date			Home Phone			☐ Yes ☐ No	☐ Yes ☐ No	

Relationship Codes: SP - Spouse CH - Child SC - Step-Child						Gender		Dental Provider ID <i>Liberty Dental Plan Only</i>	Medicare Eligible?		Other Insurance Coverage?	
Code	Last Name	First Name	MI	Date of Birth	Social Security #	M	F		Yes	No	Yes	No

Provide the Social Security Number of each dependent you enroll. Federal regulations require health plans to report the names and Social Security Numbers of every covered individual to the IRS.

*If you are adding a spouse, a separate spousal affidavit form is required for enrollment.

PROVIDER CODE(S) INSTRUCTIONS

** If you chose the Liberty Dental DHMO-EPO Plan, you and your enrolled dependents must choose a provider from the Provider Directory in the Liberty Dental packet.

If you or any of your dependents are covered by another group health insurance plan, provide the following information and attach a copy of the insurance card. If you need to list multiple individuals, please attach an additional page.	
Covered Person's Name	Insurance Company Name
Effective Date of Coverage	Name of Employer Providing Coverage

LIFE INSURANCE BENEFICIARY

Beneficiary Name	Relationship	Home Phone	
Mailing Address	City	State	Zip

AUTHORIZATION

I hereby apply to the plan(s) indicated by a "✓" above, for the coverage now being offered to myself and my dependents, if any. I hereby declare that all answers above are true and complete and that any misstatements or failure to report information may be used as the basis for rescission of insurance for me and my dependents (if any) from the original effective date. I further understand that if the insurance applied for becomes effective, I will be subject to all the terms of the group policy(ies) in effect at the time services are rendered. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical related provider or facility, insurance company, health plan including my selected plan, or other organization, employers, or other person or entity that has any information as to my health or that of any of my dependents to give my selected plan as indicated by a "✓" above, or its authorized representative, any such information. A photographic copy of this authorization shall be as valid as the original.

I certify and warrant to the Board of Trustees that all information on my enrollment form is true, correct and current as of the date I signed my enrollment form. I agree to immediately notify the Board of Trustees, in writing, of any changes in eligibility status for any dependent listed on my form. I acknowledge the right of the Board of Trustees to require of me and promptly receive from me proof of eligibility status, such as marriage licenses, birth certificates, domestic relations decree or any other proof of eligibility as the Board of Trustees, in its sole discretion, may require. I agree to promptly furnish such proof to the Board of Trustees and further agree that such proof is a condition to the payment of any benefits for or on behalf of me or my dependents.

I understand that health care benefits are not vested rights and that the Trustees have full authority to modify, limit or terminate health care benefits at any time as they deem appropriate. If the Trust Fund pays benefits for or on behalf of me or any person listed as a dependent on this form, when I am or such person is not in fact eligible or entitled to the benefits or if the Trust Fund otherwise mistakenly pays benefits, I agree to promptly reimburse the Trust Fund in full for any such monies so paid. I also agree that the Trustees, in their sole discretion, may deduct or offset any such monies from my future benefits. If the Trust Fund files any legal action against me to recover any such monies, I agree to pay all attorney's fees and costs of the Trust Fund, whether or not such an action proceeds to judgment.

Employee Signature _____ Date _____

White Copy: Administrative Office

Yellow Copy: Plan Participant