NORTHERN CALIFORNIA GENERAL TEAMSTERS SECURITY FUND
CHANGE REQUEST FORM
Tiered Plans

This form must be signed, dated and returned to Delta Fund Administrators.
All sections of this form must be completed legibly.

EMPLOYEE INFORMATION

NAME:
☐ Indicate if Change *

☐ Male
☐ Female

Last Name | **First Name** | **MI** | **Social Security Number**

***If name change, provide former name:**

☐ Single
☐ Married

Date of Birth (Mo/Day/Yr)

HOME ADDRESS:
☐ Indicate if Change

House # and Street Name or PO Box

City, State, Zip Code

PHONE:
☐ Indicate if Change

Home/Cell Phone

Email Address

NAME OF EMPLOYER:

LIFE INSURANCE BENEFICIARY:
☐ Indicate if Change

Name of Beneficiary

Relationship

COVERAGE TYPE SELECTION (Please check one box if adding or dropping dependents)

Indicate your new coverage tier:
Tier changes may result in a change to your payroll deduction; please check with your HR or Payroll department.

Employee Only ☐	EE + Spouse ☐	EE + Child(ren) ☐	EE + Family ☐

NOTE: Qualifying events/status changes must be reported to Delta Health Systems (DHS) within 31 days of a status change (newborns may be added up to 180 days after date of birth) in order for the change to be effective on the date of the event.

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DEPENDENT ENROLLMENT/DISENROLLMENT
If enrolling a newly eligible dependent, you must attach marriage and/or birth certificates

Relationship	First and Last Name	Date of Birth (Mo/Day/Yr)	Does this dependent have other group coverage?	Dependent SS #	
☐ Husband ☐ Wife			☐ No ☐ Yes – insurance company: Spouse's Employer:		☐ Add ☐ Drop
☐ Son ☐ Daughter ☐ Step-child			☐ No ☐ Yes – insurance company:		☐ Add ☐ Drop
☐ Son ☐ Daughter ☐ Step-child			☐ No ☐ Yes – insurance company:		☐ Add ☐ Drop
☐ Son ☐ Daughter ☐ Step-child			☐ No ☐ Yes – insurance company:		☐ Add ☐ Drop
☐ Son ☐ Daughter ☐ Step-child			☐ No ☐ Yes – insurance company:		☐ Add ☐ Drop
☐ Son ☐ Daughter ☐ Step-child			☐ No ☐ Yes – insurance company:		☐ Add ☐ Drop

EMPLOYEE SIGNATURE AND CONSENT

I understand that I cannot change/revoke this election during the plan year unless I experience a change in family status (i.e. marriage/divorce, birth/adoption of a child, death of a family member, involuntary termination of a spouse's employment), or move out of the service area (Kaiser only, if applicable). I understand that this election will continue in effect until modified by a subsequent election.

I understand that the Northern California General Teamsters Security Fund *["**Health Plan**"]* may use my health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. I understand that the Health Plan has established a policy to guard against unnecessary disclosure of my health information.

I authorize all health care providers, claim processing agents, insurance and reinsurance agencies or other persons or organizations performing direct administrative, professional, medical, or legal services in connection with me or my covered dependents to disclose any information necessary for investigation, evaluation, or payment of a claim.

I certify that all information contained herein is true and correct.

____________________________ __________________

Signature Date