CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
CEMENT MASONS VACATION/HOLIDAY TRUST FUND FOR NORTHERN CALIFORNIA
CEMENT MASONS PENSION TRUST FUND FOR NORTHERN CALIFORNIA
4160 Dublin Blvd, Suite 400, Dublin, CA 94568 | Telephone: (707) 864-3300 or (888) 245-5005
E-Mail Address: nccmenrollment@hsba.com | Web: http://www.norcalcementmasons.org

ENROLLMENT FORM

Part I. PARTICIPANT INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST	MIDDLE	LAST

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS *(IF DIFFERENT FROM ABOVE)*	CITY	STATE	ZIP CODE

HOME PHONE ☎ : CELL PHONE 📱:	E-MAIL ADDRESS, IF ANY	LOCAL UNION NO.	☐ *Cuando posible* prefiero recibir información de beneficios en Español.

DATE OF BIRTH MONTH DAY YEAR	GENDER	PRESENT MARITAL STATUS MONTH DAY YEAR	PRIOR MARRIAGE* (*if applicable)*
/ /	☐MALE ☐FEMALE	☐NEVER MARRIED ☐SINGLE ☐MARRIED→ *(date of marriage)* → / /	NAME OF EX-SPOUSE _____ DATE OF DIVORCE _____

Part II. DEPENDENT INFORMATION *If dependent(s) have different address than you, attach separate sheet with their address(es)

IMPORTANT: Add new or delete previously enrolled "**Dependents**" below. The term "**Dependents**" means your legal spouse, your children under age 26 regardless of marital status, and your unmarried children age 26 or older who are totally handicapped as explained in the Plan. Unless documents have been previously provided, you are required to mail the applicable document(s) below to the Trust Fund Office to substantiate your relationship to your dependent(s).

SPOUSE – Marriage Certificate *
DOMESTIC PARTNER – Read Part III Below

***If you are divorced,** you **must** provide copy of the Final Dissolution of Marriage.
Your ex-spouse will lose dependent status as of the date of dissolution.

NATURAL/STEP/ADOPTED CHILD – Birth Certificate and legal adoption document for adopted child
LEGAL GUARDIANSHIP – Guardianship papers or documents from a Court appointing you as the legal guardian
FOSTER CHILD – Proof of foster child placement or custody from a placement agency or a Court appointing you as the foster parent
Write your Social Security number on each of the document(s) for identification purposes.

Add/Delete	Relationship	Gender	Name (First, MI, Last)	Date of Birth Month Day Year	Social Security No.
☐ Add ☐ Delete	☐ Spouse, or ☐ Domestic Partner	☐ Male ☐ Female		/ /	- -
☐ Add ☐ Delete	Child	☐ Male ☐ Female		/ /	- -
☐ Add ☐ Delete	Child	☐ Male ☐ Female		/ /	- -
☐ Add ☐ Delete	Child	☐ Male ☐ Female		/ /	- -

- **You will be responsible for any incorrectly paid claims resulting from your failure to notify the Trust Fund Office of changes in dependent status, such as, but not limited to, death, divorce, or loss of legal guardianship.**
- **This form will be returned if you fail to provide the dependent's date of birth and Social Security number.**

Part III. DOMESTIC PARTNER HEALTH AND WELFARE PLAN'S ELIGIBILITY

In order to determine whether your Domestic Partner meets your Health and Welfare Plan's requirement for Domestic Partner coverage, please furnish the information below. To enroll your Domestic Partner's children, if any, you must provide the applicable documents as listed in the Dependent Information section of this form.

A written statement from your employer certifying that the employer has a job contract with the City or County of San Francisco, City of Oakland, City of Sacramento, County of San Mateo or the State of California. If the employer has entered into a contract with the State of California, they must also certify that the cumulative amount of the contract is $100,000.00 or more during the State's fiscal year.

If your employer certifies that they have entered into a job contract with the City or County of San Francisco, City of Oakland or City of Sacramento, you must provide a copy of your Domestic Partner certificate issued by any city, county or state agency.

If your employer certifies that they have entered into a job contract with the **County of San Mateo or the State of California**, you and your partner must be registered as domestic partners with the California **Secretary of State**, obtain a domestic partners certificate from the Secretary of State's office and provide a copy to the Trust Fund Office.

Part IV. OTHER INSURANCE COVERAGE INFORMATION

Do any of your dependents listed on the reverse side of this form have another employer-sponsored medical, prescription drug, dental and/or vision Plan coverage either as an employee or as a dependent?

☐ **No ::** Skip this section. **NOTE:** You must notify the Trust Fund Office *immediately* if any dependent obtains other insurance for any reason, such as entitlement to Medicare, Medi-Cal, disability, or through employment.

☐ **Yes ::** Fill in section IV. If the other insurance applies to all dependents listed on the front side of this form, complete the box below. If one or more of your dependents have more than one other insurance, make a photocopy of this section and complete for each dependent.

Do(es) the dependent(s) live with you?
☐ **Yes** ☐ **No ::** If 'No' with whom does the child live? Name: _____ Relation: _____
❗ ***if you are divorced, provide copy of any court orders pertaining to custody and/or health coverage for the dependent***

Name(s) of dependent(s) covered by other insurance:	
Name of Insured or policy holder	Relationship to Participant
Social Security number or ID number of Insured	Name of employer providing the coverage

TYPE OF BENEFITS PROVIDED	POLICY NUMBER	EFFECTIVE DATE	DEPENDENTS COVERED?
NAME & ADDRESS OF MEDICAL PLAN			☐ YES ☐ NO
NAME & ADDRESS OF DENTAL PLAN			☐ YES ☐ NO
NAME & ADDRESS OF PRESCRIPTION DRUG PLAN			☐ YES ☐ NO
NAME & ADDRESS OF VISION CARE PLAN			☐ YES ☐ NO

Part V. BENEFICIARY INFORMATION - DESIGNATION OF BENEFICIARY

1. **Health and Welfare and Vacation/Holiday Trust Funds** – *You may designate any beneficiary you wish. Any benefits due from these Funds will be paid to your named beneficiary.*
2. **Pension Trust Fund** - *If you are married, any benefits due will be paid to your surviving spouse, and not to your named beneficiary if not your spouse, in accordance with the provisions of the Pension Plan.* Contact the Trust Fund Office or refer to your Plan booklet for more information regarding payment of benefits to beneficiaries.

☐ Check here if you want to designate more than one person for one or more of the Funds. The necessary form will be mailed to you.

☐ Check here if you **do not** want to change your previously designated beneficiary.

❗ **If you do not designate a beneficiary below (and also do not check the box above), any death benefits payable will be paid equally to one or more of your surviving relatives as this Enrollment Form replaces the form you have previously filed, if any, and will be effective upon receipt by the Trust Fund Office.**

SOCIAL SECURITY NUMBER	NAME: FIRST MIDDLE LAST	RELATIONSHIP

MAILING ADDRESS	CITY	STATE	ZIP CODE

****** Please do not list 'self' as your beneficiary ******

PARTICIPANT STATEMENT – You MUST date and sign form

I hereby certify under penalty of perjury under the laws of the State of California that the information given in this form is true, correct and complete to the best of my knowledge.

DATE: SIGNATURE: