



Los Angeles Machinist Benefit Trust

Health & Welfare



**Send to: PO BOX 6149 Garden Grove,
CA 92846**

**Phone: (800) 499-8121
FAX: (925) 833-7301**

**Website
www.lambt.org**

Medical (Please choose one)	Dental (Please choose one)	Vision (Please choose one)
<input type="checkbox"/> Indemnity PPO	<input type="checkbox"/> CIGNA Indemnity	<input type="checkbox"/> MES
<input type="checkbox"/> Kaiser HMO	<input type="checkbox"/> CIGNA (DHMO)	<input type="checkbox"/> VSP
<input type="checkbox"/> Blue Shield HMO		

Last Name	First Name	MI	Social Security Number	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change/Update Effective Date:
Street or Mailing Address:	Apt#	City	State ZIP Code	
Job Title	Telephone Number			

Your Employer	Hire Date:	Division
Your Date of Birth (mm/dd/yyyy)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married - Date of Marriage: <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated

Relationship	Last Name	First Name	MI	Date of Birth	Gender M / F	Medicare? Yes / No	FULL Social Security Number
Spouse							
Child							
Child							
Child							
Child							
Child							

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.
FOR ADDITIONAL DEPENDENTS, USE OTHER SIDE

I or my family has other group hospital or medical benefits coverage. No Yes. If yes, provide insurance company name:
 If medicare, provide individual's Medicare HICN:

BENEFICIARY:

Last Name	First Name	MI	Relationship to Participant
()			
Street or Mailing Address:	Apt#	City	State ZIP Code Telephone Number

I HEREBY APPLY for the enrollment of myself and those eligible members of my family listed above for participation in the Group Health Plan provided by the Los Angeles Machinist Benefit Trust.

I UNDERSTAND that it is my responsibility to report any change in the eligibility of my dependents: and that the benefits of this plan are coordinated with those provided by any other group hospital or medical benefits.

X
 Participant Signature _____ Date _____