Los Angeles Machinist Benefit Trust
Health & Welfare

Send to: PO BOX 6149 Garden Grove, CA 92846

Phone: (800) 499-8121
FAX: (925) 405-0659

Website
www.lambt.org

Medical (Please choose one)
- ☐ Indemnity PPO
- ☐ Kaiser HMO
- ☐ UnitedHealthcare "UHC" HMO

Dental (Please choose one)
- ☐ CIGNA Indemnity
- ☐ CIGNA (DHMO)

Vision (Please choose one)
- ☐ MES
- ☐ VSP

Last Name | First Name | MI | Social Security Number

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: ☐ Male ☐ Female | Marital Status ☐ Single ☐ Widow(ed) ☐ Divorced ☐ Separated ☐ Married - Date of Marriage:

- ☐ New Enrollment
- ☐ Open Enrollment
- ☐ Change/Update Effective Date:

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