

# ENROLLMENT CHANGE FORM

ST. LOUIS GRAPHIC ARTS JOINT HEALTH & WELFARE FUND  
 14323 SOUTH OUTER FORTY ROAD, SUITE S106  
 CHESTERFIELD, MISSOURI 63017 (314) 878-1579

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 (Last Name) (First Name) (MI) (Social Security Number) (Date of Birth)

**NON-RETIREE DEPENDENT COVERAGE**-I understand that there will be no open enrollment in the future for existing dependents whom I do not cover now. If an employee declines or discontinues coverage for a dependent (including a spouse), that dependent will not be permitted to enroll at a later date unless enrollment was declined or discontinued because of the existence of other group health insurance coverage. If such other group health coverage is lost, the dependent may be enrolled in the future, provided that enrollment is requested within 30 days after the loss of the other health coverage. The loss of other coverage must be due to marital separation, divorce, death, termination of employment, reduction in work hours or termination of employer contributions toward coverage, or exhaustion of COBRA continuation or state continuation. Special enrollment is not available if the previous coverage loss resulted from fraudulent activity or from nonpayment of premiums.

**PLEASE COMPLETE APPROPRIATE SECTION**

**DEPENDENT:**

[ ] Add (Complete section below if adding new spouse, give date of marriage \_\_\_\_/\_\_\_\_/\_\_\_\_.)

IF YOU ARE ADDING A DEPENDENT AND WISH TO SWITCH TO OR FROM AN HMO, YOU MUST CONTACT THE FUND OFFICE AND COMPLETE AN APPLICATION WITHIN 30 DAYS OF ACQUIRING YOUR DEPENDENT.

[ ] Disenroll dependent(s) only (Reason: \_\_\_\_\_.)

If the reason for disenrollment is divorce, a copy of your divorce decree must be included with this completed form. If you have eligible dependent children, the divorce decree will assist us in determining which plan is primary when your children are covered under more than one medical benefit plan.

If dependent is a full-time student over age 19 or has a last name different from that of the employee, please attach appropriate documentation from school or courts.

*You are required to submit a copy of your Marriage License for your spouse and Birth Certificates for all covered dependents*

Name (Last, First,MI)	Date of Birth	Relationship	Gender	Social Security Number	Different Address
		Spouse			[ ] yes [ ] no
					[ ] yes [ ] no
					[ ] yes [ ] no

If your dependent has a different address other than yours, please list: \_\_\_\_\_

**NAME CHANGE**

From: \_\_\_\_\_

To: \_\_\_\_\_

**TELEPHONE NUMBER CHANGE**

From: ( ) \_\_\_\_\_

To: ( ) \_\_\_\_\_

**ADDRESS CHANGE**

From: \_\_\_\_\_

To: \_\_\_\_\_

**IMPORTANT:** To be effective, this form must be received by the Fund Office at the address listed above. Coverage of employee and dependents are subject to the Eligibility Rules of the Plan.

I certify that the above information is correct and complete to the best of my knowledge.

\_\_\_\_\_  
 (Signature)

\_\_\_\_\_  
 (Date)