Plan Selection Form

www.iatse504welfare.org

Notice to IATSE 504 Health plan participants

Please indicate your choices below.

- ☐ I elect Kaiser Medical Plan
- ☐ I elect United Healthcare Harmony HMO Plan
- ☐ I elect United Healthcare Signature Health HMO Plan
- ☐ I do not elect enrollment in the Medical Plans
- ☐ I elect the Delta Care Dental Plan
- ☐ I do not want the Delta Care Dental Plan

_____ _____

Print Name Social Security Number

_____ _____

Signature Date

BE SURE TO INCLUDE YOUR COMPLETED ENROLLMENT FORMS WITH THIS PLAN SELECTION FORM. IF YOU ARE ENROLLING A SPOUSE, INCLUDE YOUR MARRIAGE CERTIFICATE. IF YOU ARE ENROLLING DEPENDENTS, INCLUDE THEIR BIRTH CERTIFICATE.

SHOULD HAVE ANY QUESTIONS PLEASE CONTACT THE ADMINISTRATIVE OFFICE, (888) 806-8942.