

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST
720 Market Street, Suite 700, San Francisco, CA 94102
(415) 263-3670

PLAN and DEPENDENT CHANGE REQUEST FORM

I have read the enclosed Comparison of Benefits and would like to change to the following Plan. (Please check the appropriate box, fill in the information requested below and return this form and the information, along with the appropriate enrollment form and/or identification card, will be sent to you.)

Non-Medicare Retirees

- ☐ SELF-FUNDED PPO (AVAILABLE WORLD WIDE)
- ☐ KAISER (CALIFORNIA ONLY - must reside within a 30 mile radius of a Kaiser facility)
- ☐ BLUE SHIELD HMO (Limited to certain geographic areas in California Only - contact Plan Office for more information or the Blue Shield website @ www.blueshieldca.com).

Medicare Retirees

- ☐ SELF-FUNDED PPO (AVAILABLE WORLD WIDE)
- ☐ KAISER SENIOR ADVANTAGE (CALIFORNIA ONLY - must reside within a 30 mile radius of a Kaiser facility)

If you have had a change in dependent status or elect to add an adult child ages 19 through 25 please check the applicable box below:

- ☐ CHANGE IN DEPENDENT STATUS
- ☐ ADD ADULT CHILD AGES 19 THROUGH 25

Your Name (please print)

Signature

Social Security Number

Street Address

City, State, Zip Code

[Attached is a schedule showing the monthly co-payment rates for January 1, through December 31, 2010.]