SIMNSA
health plan

DENTAL AND HEALTH PLAN X

SIMNSA Enrollment Application - Imperial County IHSS

Last name	First name	Social Security Number	
Street Address	City	State	Zip Code
Telephone (Home or Message) ( )	Date of Birth	☐ Male ☐ Female	☐ Single ☐ Married
Name of Company Where You Work (Employer) **Imperial UDWA (Group #520)**			

Benefit Deduction Authorization

In the event payroll deductions cease, I authorize UDW's third-party processor to initiate a monthly recurring, automatic funds transfer with my financial institution to which my pay is deposited by my Employer in an amount equal to the monthly co-contribution premium I am required to pay in order to remain enrolled in the plan of Health and Welfare benefits I have selected. My current co-contribution premium is $20 per month, however this amount may change from time to time and, if so, this authorization will remain effective for any such amounts. I understand that this service is available to me as a result of my UDW membership, and if I should cease to be a member of UDW I will no longer be provided this service and the automatic deductions and payment of my premiums will cease.

Adjusting entries to correct errors is also authorized. I agree that withdrawals and adjustments to my checking or savings accounts may be made electronically and under the Rules of the National Automated Clearing House Association. My UDW membership card authorizes my Employer/State Controller to provide to UDW's payment processor my bank account information, which authorization shall also apply to for purposes of payment of my Health & Welfare premiums.

I understand that this authorization is not an indication or guarantee of enrollment or eligibility in the plan. I further understand that it is my sole responsibility to ensure my co-contribution premiums are timely made to the plan, to ensure that sufficient funds are available in my account to process on my behalf payment of premiums under this authorization, and to ensure my account information remains current and accurate.

Sign Here
& At Bottom

_____ _____

Signature #1 Date

Upon applying for membership of Sistemas Medicos Nacionales, S.A. for me and eligible members of my family, I accept the following:

1. All services should be provided solely by SIMNSA providers, except in case of a Dental Emergency (as defined in the Plan document.
2. We shall not lend our member cards to others; doing so may result in immediate cancellation of coverage and penalties.
3. I understand that SIMNSA will obtain medical information for people listed on this application in order to administer the Plan.
4. I certify that the information on this application is valid and correct and that I understand the benefits and rules of this health Plan.
5. This Plan uses binding arbitration to settle all disputes arising under this Agreement. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered in California under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. For more information, please refer to your Evidence of Coverage.

Administrative use only

Effective Date: _____

☐ New Hire Hire Date _____
☐ Re-Hire Re-Hire Date _____

_____

Signature #2

_____

Date