Please send a $3.00 check or money order payable to UDW to pay for 1st month!

OVER

Dental Health Services Enrollment Form Formulario de Inscripción

Effective Date / Fecha Efectiva de Cambio _____ Preferred Language/Idioma Preferido _____

Employee information / Información del empleado

Name/Nombre _____ Social Security # / # Seguro Social _____

Address/Dirección _____

City/Ciudad _____ State/Estado _____ Zip Code/Zona Postal _____

Phone Number/Nùmero de Teléfono _____ Email/Correo Electrónico _____

Date of Birth/Fecha de Nacimiento _____ Gender/Sexo _____

Company information / Información de su empleador

Company Name/Nombre de la Compañia UDW San Diego – Trust Administration Office

Group Number/Numero de Grupo 3977H

Address/Dirección 940 Calle Negocio #110

City/Ciudad San Clemente State/Estado CA Zip Code/Zona Postal 92673

Date of Hire/Fecha de Emplea _____

Dentist Number / Numero de dentista

_____

Enrollment Information / Información de su plan

x Employee only
Empleado

For dental benefit questions call – 877.890.7023
For eligibility questions call our trust administration office – 800.883.0902

Please return this application to
UDW San Diego Trust Administration Office
940 Calle Negocio #110
San Clemente, CA 92673

I hereby request coverage and authorize payroll deductions (if applicable) from my earnings for any contributions required for a minimum of one year. Authorization is granted to release my patient history to Dental Health Services, consulting health professional, or other entity designated or approved by Dental Health Services for the purpose of certifying, purchasing, providing, evaluating, or administering benefits. This authorization remains in effect until revoked by me in writing / En representación de mí mismo y de mis dependientes elegibles, por la presente solicito cobertura dental que he indicado de Dental Health Services y que me fuera ofrecido a traves de mi empleador. Coincido las deducciones en la nómina (si aplica) de mi salario para la contribución adequada el minimo de un año. Coincido dar la authorización para conceder información relaciondada con mi historia médica a Dental Health Services, consultante professional medica u otra entidad aprobada por Dental Health Services para el propósito de certificar, evaluar o administrar beneficios. Esta authorización es efectiva hasta que sea revocada por mi escrito.

By signing this dental enrollment application I am agreeing to a $3 monthly payroll deduction for this dental plan.

Employee signature/Firma del empleado Date/Fecha

1G046

Official Use Only
Authorized by _____ Group Number 3977H Date _____

UDW The Homecare Providers Union

United Domestic Workers of America
AFSCME Local 3930 /AFL-CIO

SAN DIEGO DENTAL INSURANCE QUESTIONNAIRE

(This form must be returned with your enrollment forms to be enrolled)

YOUR NAME (as if appears on your state payroll check):

_____

SOCIAL SECURITY NUMBER: _____

AUTHORIZED HOURS PER MONTH FOR ALL CLIENTS: _____

DATE OF HIRE FOR FIRST CLIENT: _____

SIGNATURE: _____

PLEASE CHECK ALL OF THE FOLLOWING (if they apply):

☐ I am currently working a minimum of 80 hours per month and I understand that I must maintain minimum working hours of 80 paid hours per month to remain eligible for dental insurance

☐ I understand and agree to pay through payroll deduction or by invoice a $3.00 monthly premium co-pay for my dental insurance and failure to do so will result in losing dental benefits. You will be canceled from the dental benefits if you have one un-paid invoice for more than 30 days.

Please note: If your hours drop below 80 hours worked per month because of your illness or your client is hospitalized, etc., please let us know immediately. Call our San Diego County Trust Administration office at (800)-883-0902 – Goldman & Walker Insurance Services, LLC.

RETURN THIS QUESIONNAIRE AND THE DENTAL ENROLLMENT FORM IN THE SELF ADDRESSED ENVELOPE ASAP. WE ARE CURRENTLY RUNNING A WAITING LIST FOR YOUR DENTAL BENEFITS

San Diego County Trust Administration Office: 940 Calle Negocio • Suite 110 • San Clemente, CA 92673
Tel. Toll Free (800) 883-0902 • Fax: (949) 545-0167 • E-mail: gwalker@goldmanwalker.com