Hotel and Casino Workers
TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA

P.O. Box 26779
Las Vegas, NV 89126-0779

Phone: (702) 734-8601
Fax: (702) 734-8619

Enrollment Form

Please print in black ink or type. Complete, sign and return this form to the address noted at left.

Check one box for each category: **MEDICAL** ☐ PPO Plan (Anthem BlueCross BlueShield Network) ☐ HMO Plan (Health Plan of Nevada)* **DENTAL** ☐ Diversified Dental PPO Plan ☐ Liberty Dental HMO Plan**

Last Name	First Name	MI	Date of Birth	Social Security #	☐ Male ☐ Female

Mailing Address	City	State	Zip	Email Address	Home Phone

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Date of Marriage	Date of Divorce	Physician Code(s)*		Medicare Eligible?		Other Insurance Coverage?	
			Primary	Ob-Gyn	☐ Yes	☐ No	☐ Yes	☐ No
Current Employer	**Hire Date**							

Relationship Codes: **SP** - Spouse **CH** - Child **SC** - Step-Child						Gender		Physician Code(s)* *HMO Plan Only*		Dental Provider ID *Dental HMO Plan Only*	Medicare Eligible?		Other Insurance Coverage?	
Code	Last Name	First Name	MI	Date of Birth	Social Security #	M	F	Primary	Ob-Gyn		Yes	No	Yes	No

Provide the Social Security Number of each dependent you enroll. Federal regulations require health plans to report the names and Social Security Numbers of every covered individual to the IRS.

PROVIDER CODE(S) INSTRUCTIONS

* If you chose the HMO Plan, you and your enrolled dependents must choose a primary care physician from the HPN Primary Care Network Physician list. Females, no matter what age, must also choose an Ob-Gyn.

** If you chose the Liberty Dental HMO Plan, you and your enrolled dependents must choose a provider from the Provider Directory in the Liberty Dental packet.

If you or any of your dependents are covered by another group health insurance plan, provide the following information and attach a copy of the insurance card. If you need to list multiple individuals, please attach an additional page.

Covered Person's Name	Insurance Company Name
Effective Date of Coverage	Name of Employer Providing Coverage

LIFE INSURANCE BENEFICIARY

Beneficiary Name	Relationship	Home Phone	
Mailing Address	City	State	Zip

AUTHORIZATION

I hereby apply to the plan(s) indicated by a "✓" above, for the coverage now being offered to myself and my dependents, if any. I hereby declare that all answers above are true and complete and that any misstatements or failure to report information may be used as the basis for rescission of insurance for me and my dependents (if any) from the original effective date. I further understand that if the insurance applied for becomes effective, I will be subject to all the terms of the group policy(ies) in effect at the time services are rendered. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical related provider or facility, insurance company, health plan including my selected plan, or other organization, employers, or other person or entity that has any information as to my health or that of any of my dependents to give my selected plan as indicated by a "✓" above, or its authorized representative, any such information. A photographic copy of this authorization shall be as valid as the original.

I certify and warrant to the Board of Trustees that all information on my enrollment form is true, correct and current as of the date I signed my enrollment form. I agree to immediately notify the Board of Trustees, in writing, of any changes in eligibility status for any dependent listed on my form. I acknowledge the right of the Board of Trustees to require of me and promptly receive from me proof of eligibility status, such as marriage licenses, birth certificates, domestic relations decree or any other proof of eligibility as the Board of Trustees, in its sole discretion, may require. I agree to promptly furnish such proof to the Board of Trustees and further agree that such proof is a condition to the payment of any benefits for or on behalf of me or my dependents.

I understand that health care benefits are not vested rights and that the Trustees have full authority to modify, limit or terminate health care benefits at any time as they deem appropriate. If the Trust Fund pays benefits for or on behalf of me or any person listed as a dependent on this form, when I am or such person is not in fact eligible or entitled to the benefits or if the Trust Fund otherwise mistakenly pays benefits, I agree to promptly reimburse the Trust Fund in full for any such monies so paid. I also agree that the Trustees, in their sole discretion, may deduct or offset any such monies from my future benefits. If the Trust Fund files any legal action against me to recover any such monies, I agree to pay all attorney's fees and costs of the Trust Fund, whether or not such an action proceeds to judgment.

MemberSignature _____ **Date** _____

White Copy: Administrative Office Yellow Copy: Plan Participant