



# ADD/DELETE DEPENDENTS FORM

## RIVERSIDE COUNTY ELECTRICAL HEALTH & WELFARE TRUST FUND

2831 Camino del Rio S. #311  
 San Diego, CA 92108  
 (800) 736-0401

THE PURPOSE OF THIS FORM IS TO ADD OR DELETE DEPENDENTS IN THE RIVERSIDE COUNTY ELECTRICAL HEALTH & WELFARE PLAN. THIS INCLUDES ENROLLMENT/DIS-ENROLLMENT IN THE INDEMNITY MEDICAL PLAN. **IF YOU ARE ENROLLED IN AN HMO, YOU MUST COMPLETE THAT HMO'S REQUIRED FORM IN ORDER TO MAKE THIS CHANGE APPLY TO YOUR HMO.**

### YOUR NAME

LAST NAME		FIRST NAME		M.I.	SOCIAL SECURITY NUMBER	
MAILING ADDRESS (STREET OR P.O. BOX)					SEX	DATE OF BIRTH
CITY	STATE/ZIP	TELEPHONE NUMBER (     )		EMAIL ADDRESS		

### ADD/DELETE DEPENDENT SPOUSE

SPOUSE'S NAME	ADD/DELETE	EFFECTIVE DATE	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH

- To **ADD** a spouse, you must include a copy of your marriage certificate.
- To **DELETE** a spouse, you must include a copy of your divorce decree or your legal separation agreement, as appropriate.

### ADD/DELETE DEPENDENT CHILD

CHILD'S NAME	ADD/DELETE	EFFECTIVE DATE	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH

- To **ADD** a child, you must include a copy of the child's birth certificate or adoption certificate, as appropriate.

**I HEREBY DECLARE THAT ALL STATEMENTS AND ANSWERS ABOVE ARE TRUE, AND THAT THEY ARE THE BASIS ON WHICH COVERAGE MAY BE EXTENDED UNDER THE PLAN.**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

INTERNAL OFFICE USE ONLY
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