University of Massachusetts Lowell /SEIU 888
Health and Welfare Fund
25 Braintree Hill Park, Suite 306
Braintree, MA 02184
Phone: (617) 241-3367 **Fax:** (617) 241-3303
Email: ldeluca.funds@seiu888.org

Enrollment & Change Form

Subscriber Information

Hire Date____/____/____ Effective Date____/____/____ Term Date____/____/____ Change Eff. Date____/____/____

Employer:_____

Please indicate: ☐ New Employee ☐ Open Enrollment
☐ Change of Address

Please indicate reason(s) for change or enrollment:

☐ Add Dependent Coverage – Reason:_____(if requesting coverage for employee's spouse____/____/____)
date of marriage
☐ Terminate Dependent Coverage – Reason:_____
☐ Change of Status – Reason: _____
☐ Other: _____

Employee Last Name	*First Name*	*MI*	*Social Security Number*	*Date of Birth*

Mailing Address	*City*	*ST*	*ZIP Code*	*Home Phone*	*Email*

Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Dependent Information

Copies of the following required documentation for all dependents must accompany this enrollment form:
Employee + Spouse: Marriage Certificate
Employee + Child(ren): Birth Certificate(s)
Employee + Spouse + Child(ren): Marriage Certificate & Birth Certificate(s)

Last Name	*First Name*	*MI*	*Gender*	*Date of Birth*	*Relationship*	*Dependent Social Security Number (REQUIRED)*	*Add Dependent*	*Remove Dependent*
								Initial____
								Initial____
								Initial____
								Initial____
							☐	☐ Initial____

Election of Coverage

******Important***** **To accept coverage indicate your benefit choice, select YES, then sign, and date below.**

Dental	**Vision**
☐ Blue Cross Blue Shield	☐ Davis Vision

☐ **YES** • *I wish to elect coverage under the University of Massachusetts Lowell/SEIU 888 Health and Welfare Fund for the coverages indicated above. I understand that my application will be subject to the terms of the Plan. I certify that the above information is accurate and complete.*

Signature: _____ _____
Signature of Employee *Date Signed*

Signature: _____ _____
Signature of Employer *Date Signed*

Please send completed forms to:
University of Massachusetts Lowell /SEIU 888 H&W Fund
PO BOX 1010, Burlington, MA 01803
Fax: 617-241-3303 Email: ldeluca.funds@seiu888.org

INTERNAL USE ONLY

____E-mailed Fax USPS

Received By: _____
Enrolled : _____
Date: _____