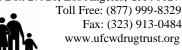
## Southern California Drug Benefit Fund

P. O. Box 27920, Los Angeles, CA 90027 Toll Free: (877) 999-8329 Fax: (323) 913-0484

(If married, New Hires must submit proof of marriage)

Last Name



☐ Change of Address

1. PARTICIPANT INFORMATION (please print and use blue or black ink)

First Name

## **ENROLLMENT FORM – PLATINUM PLUS**

Social Security Number

☐ Change Plan(s) ☐ Transfer

Add/Delete Dependents

Mid. Initial

	Chock if	address is new.	City		St	ate	ZIP code	Date of Bi	rth (mm/dd/yyyy)
Mailing Address Street:	LI CHECK II								
Home phone ( )			□ Married □ Single	Gender		Date of Marria (attach proof of	ge or Domestic I	Partnership rship)	☐ Divorced ☐ Widowed
Mobile phone ( )	<u> </u>	]	Ū	ic Partnership					
Employer Store	e# Worl	R Phone		Date of Hire (mm/dd/yyyy	/) Job ¯	itle Employ	ee ID#	Union Loc	cal
2. DEPENDENT INFORMATI	ION								
I wish to enroll add required for newly enrolled Dependenrollment right.	delet	e the Depen dren. Note: De	dents lis ependent	sted below. A Marriaç additions are allowed o	e Certificantly during	ate is required the annual O	l (if adding spo pen Enrollmen	ouse) and Birth at or if there is a	Certificates are special
Spouse Domestic Partner			SS	SN or TIN (required)		Gender (M	F)	Date of Birth	
Child			SS	SN or TIN (required)		Gender (M	F)	Date of Birth	
Child			SS	SN or TIN(required)		Gender (M	F)	Date of Birth	
Child			SS	SN or TIN (required)		Gender (M	F)	Date of Birth	
ote: To enroll more Children, p									
. PLAN SELECTION (PLAN (	CHANGES A	RE ALLOWED C	ONLY DUR	RING THE OPEN ENROLL	MENT PER	IOD OR IF THE	RE IS A SPECI	IAL ENROLLME	NT RIGHT)
ligible participants, except for in the 2 <sup>nd</sup> annual open enrollm	ent after tl	neir hire date.	·				-		·
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