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____/____/_____

Please indicate: ☐ New Employee ☐ Open Enrollment
☐ Change of Address
☐ Add Dependent Coverage – Reason:_____(if requesting coverage for employee's spouse__/__/____)
☐ Terminate Dependent Coverage – Reason:_____ *date of marriage*
☐ Other: _____

Please indicate reason(s) for change or enrollment:

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 choices, select YES, then sign and date below.**

Dental	**Vision**
☐ Delta Dental PPO Plus Premier	☐ 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.*

Employee Signature:_____ **Date:** _____

Employer Signature:_____ **Date:** _____

Please send completed forms to:
University of Massachusetts Lowell/SEIU 888 Health & Welfare Fund
25 Braintree Hill Park, Suite 306 Braintree, MA 02184
Fax: 617-241-3303 Email: ldeluca.funds@seiu888.org

INTERNAL USE ONLY

____E-mail Fax Mail

Received By: _____
Enrolled: _____
Date: _____