LOS ANGELES MACHINIST BENEFIT TRUST

1325 N. Grand Ave. • Suite 200
Covina, CA 91724

MEDICAL (PLEASE CHOOSE ONE):
__ INDEMNITY
__ KAISER
__BLUE SHIELD

DENTAL (PLEASE CHOOSE ONE):
__ UNITED CONCORDIA (INDEMNITY)
__ UNITED CONCORDIA (DHMO)

Elect only the applicable Plan that has been negotiated for you or call 800-499-8121 to verify.

PLEASE PRINT

❑ NEW ENROLLMENT
❑ OPEN ENROLLMENT
❑ CHANGE/UPDATE
EFFECTIVE DATE: _____

YOUR NAME	Last Name	First Name	Initial	
YOUR HOME ADDRESS	Street Address	Apt#	Social Security Number	
	City and State	Zip Code	Occupation	Phone Number
	NAME OF EMPLOYER		Date Employed Mo. Day Year	Division

YOUR DATE OF BIRTH	Date Employed Mo. Day Year	CHECK ONE	Male	Female	CHECK ONE	Married	Single	Widowed	Divorced

TO ENROLL DEPENDENTS **List ALL Eligible Family Members**

Relationship	Last Name	First Name	Initial	Date of Birth Mo.	Day	Year	Date of Marriage / Social Security Number
❑ Husband ❑ Wife							Social Security Number
❑ Son ❑ Daughter							Social Security Number
❑ Son ❑ Daughter							Social Security Number
❑ Son ❑ Daughter							Social Security Number
❑ Son ❑ Daughter							Social Security Number
❑ Son ❑ Daughter							Social Security Number
❑ Son ❑ Daughter							Social Security Number

FOR ADDITIONAL DEPENDENTS USE OTHER SIDE

PLEASE PRINT (Complete this section only when **GROUP LIFE INSURANCE** provided)

Last Name	First Name	Initial

NAME OF BENEFICIARY

Street Address	Apt#	Relationship
City and State	Zip Code	Phone Number

I HEREBY APPLY for the enrollment of myself and those eligible members of my family listed above for participation in the Group Health Plan provided by the Los Angeles Machinist Benefit Trust.
I UNDERSTAND that it is my responsibility to report any change in the eligibility of my dependants; and that the benefits of this plan are coordinated with those provided by any other group hospital or medical benefits.

Date Signed _____ 20 _____ YOUR SIGNATURE _____