Health & Security Plan
Benefits Enrollment and Change Form

125 Barclay St., New York, NY 10007
Email: eeu@dc37.net – T: 212-815-1234 – F: 212-298-9880

Please print all information clearly using a black or blue ballpoint pen. See reverse for instructions.

A. REASON(S) FOR SUBMISSION (Check one or more boxes if applicable)

NEW ENROLLMENT ☐	**Complete sections A, B, C, D, E, F, and G**	
CHANGE OF ☐	☐ Spouse/Domestic Partner: ☐ Add ☐ Drop Eff: Date:	**Complete sections A, B, C, and G**
☐ Dependent Child(ren): ☐ Add ☐ Drop	**Complete sections A, B, D, and G**	☐ Change of Address **Complete sections A, B, and G**
☐ Change of Name – Former Name: (Attach legal documents)		**Complete sections A, B, and G**

B. EMPLOYEE / MEMBER INFORMATION (Name, SSN / PID, and DOB are Required for New Enrollment and Change)

Last Name:	First Name:	M.I.	Soc. Sec. No. / PID:	Date of Birth:
Home Address:		Apt.:	Sex Assigned at Birth: ☐M ☐F	Mobile/Home Tel. Number:
City:	State:	Zip Code:	Email Address:	
Country (if outside the U.S.):	Marital Status: ☐ Single, ☐ Married, ☐ Domestic Partnership, ☐ Divorced, ☐ Widowed, ☐ Separated			

C. SPOUSE/DOMESTIC PARTNER - ONLY COMPLETE IF YOUR SPOUSE/DOMESTIC PARTNER IS TO BE COVERED. IF NOT, LEAVE BLANK.

Last Name:	First Name:	M.I.:	Social Security Number:	Date of Birth:
Sex Assigned at Birth: ☐M ☐F	Is your spouse/domestic partner a member of a Union? ☐Yes ☐No	Name of Union:		
Is your spouse/domestic partner Medicare eligible? ☐Yes ☐No	If yes, attach a copy of your spouse/domestic partner Medicare Card	Attach a copy of your Marriage Certificate / Domestic Partner Registration		

D. DEPENDENT(S) INFORMATION (Attach BIRTH CERTIFICATE / ADOPTION DOCUMENTS – For additional dependents, attach second form if necessary.)

List all eligible dependent children. Indicate if you are adding or dropping coverage by checking the appropriate box below.

Dependent's Last Name:	Dependent's First Name:	Date of Birth:	Social Security Number:	Sex Assigned at Birth: ☐M ☐F	Add	Drop	Permanently Disabled
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

E. BENEFICIARY(IES) INFORMATION: Death Benefits / Annuity Benefits* to be paid.
(*not all DC37 members have an Annuity. For those who do, annual statements are mailed in August.)

Last Name:	First Name:	M.I.:	Date of Birth:	Relationship:
Home Address:		Apt.:	Sex Assigned at Birth: ☐M ☐F	Telephone Number:
City:	State:	Zip Code:	Email Address:	
Last Name:	First Name:	M.I.:	Date of Birth:	Relationship:
Home Address:		Apt.:	Sex Assigned at Birth: ☐M ☐F	Telephone Number:
City:	State:	Zip Code:	Email Address:	
Last Name:	First Name:	M.I.:	Date of Birth:	Relationship:
Home Address:		Apt.:	Sex Assigned at Birth: ☐M ☐F	Telephone Number:
City:	State:	Zip Code:	Email Address:	

F. CONTINGENT BENEFICIARY INFORMATION: In the event the primary beneficiary(ies) predecease(s) the employee/member, I designate as contingent beneficiary:

Last Name:	First Name	M.I.:	Date of Birth:	Relationship:
Home Address:		Apt.:	Sex Assigned at Birth: ☐M ☐F	Telephone Number:
City:	State:	Zip Code:	Email Address:	

G. ATTESTATION: I hereby certify that all information provided on this form is true, complete, and accurate. I acknowledge that any false or misleading information may result in the termination of benefit coverage for myself and any listed dependents.

Employee / Member Signature: **Date:**

Instructions for Completing the Health & Security Plan Benefits Enrollment and Change Form

The purpose of this form is to enroll you and your eligible dependent(s) in the Plan, providing access to your Welfare Fund benefits through the District Council 37 Health and Security Plan.

This form is also used to update your existing information with the District Council 37 Health and Security Plan, including any changes to your enrollment status.

Please complete the applicable sections of the form and submit all required documentation to ensure accurate and timely processing of your request.

Section A: Reason for Submission
Please complete this section by indicating the reason for your submission. Check all applicable box(es).

Section B: Employee / Member Information Only
Required for all submissions always: your name, SSN or PID and date of birth.

New Enrollment:
If you are a new employee enrolling in the Plan for the first time, please complete **Sections B, C, D, E, F, and G.**

If you are enrolling a spouse, domestic partner, and/or dependent child(ren) for the first time, you must also complete **Sections C and D** and submit the required documentation, as outlined below:

- Marriage certificate – required for spouse enrollment
- Domestic partnership documentation – required for domestic partner enrollment
- Birth certificate(s) and/or other legal documentation – required for dependent child(ren) enrollment

For Changes – Previously Enrolled Employees / Members:
If you are already enrolled and need to make updates or additions to your enrollment status, please provide your first and last name, Social Security Number (SSN) or Personal Identification Number (PID), and date of birth in **Section B**. Then, complete all other applicable **sections** related to your requested changes or additions.

Changes may include:

- Name – must include legal documentation (e.g., court order, marriage certificate)
- Marital status
- Address, telephone number, or email
- Beneficiary(ies)

Additions may include:

- Spouse or Domestic Partner – must include a marriage certificate or domestic partnership certificate.
- Dependent Child(ren) – must include a birth certificate and/or other legal documentation.

Section C: Spouse / Domestic Partner
Complete this section ***ONLY*** if your spouse or domestic partner is to be covered by the Plan.

Section D: Dependent(s)
List all eligible dependent child(ren) to be covered by the Plan.

Section E: Beneficiary(ies)
Designate the individual(s) to whom your Death and/or Annuity benefits should be paid.* Please note: (*Not all DC 37 members have an Annuity benefit. For those who do, annual Annuity statements are mailed in August.)

Section F: Contingent Beneficiary(ies)
In the event that the primary beneficiary(ies) predecease the employee/member, please designate one or more contingent beneficiary(ies).

Section G: Signature Requirement
Please be sure to sign and date this Benefits Enrollment and Change Form before submitting it. Incomplete forms without a signature and date will delay processing.

You can submit a completed and signed Benefits Enrollment and Change Form by mail, email or fax:

DC 37 Health & Security Plan
125 Barclay Street
New York, NY 10007
Attn: Eligibility Enrollment Unit

Email: eeu@dc37.net

Fax: 212-298-9880

Retain a copy for your records.