Airconditioning and Refrigeration Health and Welfare Trust Fund

3500 W. ORANGEWOOD AVENUE, ORANGE CA 92868 • PHONE: (714) 917-6100 • FAX: (714) 917-6065

MEDICAL AND/OR DENTAL ENROLLMENT PLAN CHANGE REQUEST FORM

I request to be enrolled in the following plan(s) effective the first of the following month in which this signed request and if needed a completed HMO enrollment form is received.

Medical option:

- ☐ BLUE SHIELD PPO MEDICAL
  (With Navitus Pharmacy Manager)
- ☐ BLUE SHIELD LOCAL ACCESS + HMO MEDICAL
  (Enrollment form required)
- ☐ KAISER HMO MEDICAL
  (Enrollment form required)

Dental option:

- ☐ DELTA DENTAL (PPO DENTAL)
- ☐ UNITED CONCORDIA DENTAL (DHMO DENTAL)
  (Enrollment form required)

_____
Name

_XXX-XX-_____
Social Security Number

_____
Signature Date

_____
Phone Number Email

Medical and Dental plan changes are allowed once every 12 months