ENROLLMENT FORM

BAY AREA AUTOMOTIVE GROUP WELFARE FUND

4160 DUBLIN BLVD., #400 • DUBLIN, CALIFORNIA 94568

TYPEWRITTEN OR PRINTED IN INK ONLY

PLEASE READ CAREFULLY: This enrollment form is to be completed and signed by the employee only and all requested information must be provided. Applications containing illegible, missing or incomplete information will not be accepted. All information appearing on your application for coverage is subject to verification and periodic audit. Applications containing false, inaccurate or misleading information (including omissions) will be grounds for denial of some or all benefits available under the Trust. In the event that benefits are granted based on information that is later determined to be inaccurate, false or misleading, Bay Area Automotive Group Welfare Fund reserves the right to review certificates of marriage and any other documentation of dependent relationships as well as the right to recover any and all funds paid as the result of the fraudulent information, as authorized by law.

I have read and understand the above: _____ EMPLOYEE'S SIGNATURE _____ DATE

1. SOCIAL SECURITY NUMBER	2. NAME (Last) (First) (Middle)	3. DATE OF BIRTH _____ MONTH/DAY/YEAR	SEX MALE ☐ FEMALE ☐
4. ADDRESS (NUMBER) (STREET)		HOME PHONE ( ) AREA CODE	
5. CITY STATE ZIP CODE		6. CELL PHONE ( ) AREA CODE	
7. EMPLOYER		8. WORK PHONE ( ) AREA CODE	

DEPENDENT INFORMATION

9. Please complete the following dependent enrollment information. If married, you must provide a copy of your marriage certificate. If in a domestic partnership, see reverse. You must provide a birth certificate for each eligible dependent child. If your child is adopted or if you are a court-appointed guardian, please submit adoption papers or court papers establishing your legal guardianship in lieu of birth certificate. Please indicate if you are enrolling a stepchild by writing "step" in the relationship box. See additional information on back.

	FULL FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	SOCIAL SECURITY NO. (MUST BE PROVIDED)	RELATIONSHIP Spouse	Son	Daughter	Dom. Part.	Other*
A.										
B.										
C.										
D.										
E.										

*If you have checked "Other", please explain _____

10. If you have more than 5 dependents, check here ☐ and see instructions on back page.

11. Does anyone listed on this form have health insurance through another source? ☐ YES ☐ NO If Yes, name of other coverage and persons covered: _____

BENEFICIARY INFORMATION

12. Death Benefits, if applicable, are to be paid to:
Give person(s) full Legal Name, Relationship, Address and Social Security Number. If a minor, also list Guardian. The person(s) named will be considered your beneficiary unless you specify otherwise.

NAME(S) _____ RELATIONSHIP _____

ADDRESS _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____

If Beneficiary is a minor, please provide name of Guardian _____

13. I certify that all statements and information provided by me represents a complete and truthful disclosure and that each individual named on this form is either my lawfully wedded spouse or my true and legal dependent child(ren).

X _____ EMPLOYEE'S SIGNATURE _____ DATE

Each participant must notify the Administrative Office promptly when any change occurs in family status due to marriage, birth of a child, death, dissolution of marriage (divorce) or change of beneficiary. A new Enrollment Form must be completed and mailed to the Administrative Office when a change occurs.

Dear Participant:

You should carefully complete this enrollment form and fill in the required information as neatly and clearly as possible. This information is an important part of your official record with the Fund. Most of the items clearly indicate the information required; however, instructions are listed below for those items which might need explaining.

ITEM 1 Fill in your Social Security Number as it appears on your Social Security card.

ITEM 3 Please fill in the month, day and year of your birth. The year alone is not enough.

ITEM 9 The Fund has the right to request proof of marriage, of divorce, or of birth to verify the information given and to determine the eligibility of a dependent for enrollment.

Eligible dependents are:

I. Your lawful spouse. In the event of a final dissolution of your marriage (divorce), the spouse is no longer eligible for coverage and you should immediately complete and mail a new enrollment form to the Fund Office to delete your spouse as your dependent. If you fail to do so, you may be held responsible for repayment of any benefits provided to which your former spouse is no longer entitled. (CERTIFICATION REQUIRED: Certified Marriage Certificate, recorded final marriage dissolution document.)

II. Your domestic partner.* In the event of termination of domestic partnership, the domestic partner is no longer eligible for coverage and you should immediately complete and mail a new enrollment form to the Fund Office to delete your dependent. If you fail to do so, you may be held responsible for repayment of any benefits provided to which your former domestic partner is no longer entitled. (CERTIFICATION REQUIRED: Notarized Declaration of Dependency Form (obtain from Administrative Office), and Certificate of Domestic Partnership (City and County of San Francisco), or Notarized Declaration of Domestic Partnership (State of Calif.), Termination of Domestic Partnership.)

III. Your unmarried children under age 19 who are financially dependent upon you or for whom you must contribute support by order of the court. Stepchildren, children of domestic partners and adopted children entirely supported by the participant are also included. (CERTIFICATION REQUIRED: Birth Certificate, Legal Guardianship papers.)

IV. Your unmarried children under age 26 provided they do not have insurance coverage through their own or their spouse's employment.

V. An unmarried child of any age who is unable to earn a living because of a disability is also considered an eligible dependent, provided the child was both disabled and eligible under the Fund before reaching age 19 and provides proof of disability before reaching age 19. (CERTIFICATION REQUIRED: Physician Statement.)

ITEM 10 If you have more than 5 eligible dependents, obtain an additional enrollment form and mark it "FORM 2" at the top. On Form 2, complete items 1 through 6 then list your additional dependents under item 8.

ITEM 13 Be sure to sign and date this form and return it to the Trust Fund Office. Also, be certain you have listed all dates of birth correctly.

*The employee will be required to make monthly payments on the employee portion of payroll taxes for the value of the benefit received by his/her domestic partner.

AFTER YOU HAVE COMPLETED THE REVERSE SIDE OF THIS FORM, RETURN IT TO:

Bay Area Automotive Group Welfare Fund
Attn: Enrollment Desk
4160 Dublin Blvd., #400
Dublin, CA 94568