



INSTRUCTIONS FOR FILLING OUT ENROLLMENT/CHANGE FORMS DURING OPEN ENROLLMENT

1. Fill in Employee information section.
2. Check reason. If you are changing to Keystone HMO make sure you put in Keystone HMO 15/30 or Keystone HMO 20/40.
3. Check marital status and coverage choice.
4. If you are switching to Keystone HMO 15/30 or Keystone HMO 20/40, you must fill in the primary office number of your doctor. This is the Keystone HMO Office Primary ID Number, **NOT THEIR PHONE NUMBER**. You can call your doctor's office and get this number or look it up in the Keystone booklet. The list of Keystone doctors is available at www.ibx.com.
5. Sign and date the change form and return two (2) copies to the Fund at 1606 Walnut Street, Philadelphia, PA 19103 or hand deliver. **NO FAXES PERMITTED**.

Return by December 16, 2011.



HEALTH AND WELFARE FUND
 AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES - AFL-CIO
 1606 WALNUT STREET, 5TH FLOOR, PHILADELPHIA, PA 19103 (215) 546-9880

ENROLLMENT/CHANGE FORM
 (USE PEN AND PRESS FIRMLY)

FOR DEPARTMENT USE ONLY	
_____ :	_____
_____ :	_____

EMPLOYEE INFORMATION:

REASON:

LAST NAME, FIRST NAME, M.I. _____ SOCIAL SECURITY No. _____ HOME ADDRESS _____ APT. NUMBER _____ CITY, STATE _____ ZIP CODE _____ HOME TELEPHONE _____ EMPLOYER NAME _____ DATE OF HIRE _____ WORK ADDRESS _____ ZIP CODE _____ WORK TELEPHONE _____			<input type="checkbox"/> NEW APPLICATION <input type="checkbox"/> ADD/DROP DEPENDENTS <input type="checkbox"/> CARRIER CHANGE (ENTER PLAN NAME) FROM: _____ TO: _____ <input type="checkbox"/> OTHER: _____
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MARITAL STATUS:

- Single
- Married
- Divorced

CHECK ONE: Employee only Employee and 1 Dependent Employee and 2 or more Dependents

Last Name	First	M.I.	Dependent Add Remove	Sex	Birthdate Mo/Day/Yr	Social Security Number	Primary Office Number	Primary Name
Employee			<input type="checkbox"/> <input type="checkbox"/>	M F				
Spouse			<input type="checkbox"/> <input type="checkbox"/>	M F				
*Oldest Child			<input type="checkbox"/> <input type="checkbox"/>	M F				
*Child			<input type="checkbox"/> <input type="checkbox"/>	M F				
*Child			<input type="checkbox"/> <input type="checkbox"/>	M F				
*Child			<input type="checkbox"/> <input type="checkbox"/>	M F				
*Child			<input type="checkbox"/> <input type="checkbox"/>	M F				

*Dependent data subject to verification

I authorize payment of medical benefits available under this plan to appropriate provider of medical services. I represent that all information supplied in this application is true and complete and acknowledge the furnishing of incorrect information may invalidate my selection. Applicant authorizes any hospital, physician, or the health care provider to furnish the insurance carrier with such medical information about the applicant and of the listed dependents as the insurance carrier may require.

Employee _____ Fund _____ Effective _____
 Signature _____ Date _____ Authorized _____ Date _____ / ____ / ____

Mail first two copies back to Fund and keep last copy.

