SOUTHERN OPERATORS HEALTH FUND

Administrated by Southern Benefit Administrators, Incorporated

Mailing Address:
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Goodlettsville, TN 37070-1449

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Toll Free: (800) 831-4914
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Street Address:
2001 Caldwell Drive
Goodlettsville, TN 37072-2328

ENROLLMENT FORM

Please complete this form in its entirety, front and back and return it to the MAILING ADDRESS above. The information requested below is very important as it provides the Fund office with current information about you and your dependents. Please only list those dependents who meet the definition of an Eligible Dependent, as that term is defined in your Summary Plan Description. This form also allows you to designate a beneficiary for the purpose of receiving benefits from the Fund upon your death. Please sign and date the form.

The "Patient Protection and Affordable Care Act", a health care reform bill enacted by Congress and signed into law by the President in March 2010, provides that group health plan that cover dependent children not be excluded based on the following criteria: financial dependency, residency, student status, marital status, employment or eligibility for other coverage. **By completing and signing this form, you are certifying that you wish to apply for coverage for the dependents named below.**

INFORMATION REGARDING YOU AND YOUR DEPENDENTS

Participant Name: _____ **Date of Birth:** _____ **Sex:** _____

Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Social Security No:** _____ **Local #:** 926

Participant's Email Address: _____ **Phone#:** _____

Spouse's Email Address: _____ **Phone#:** _____

Spouse's Name: _____ **Date of Birth:** _____ **Sex:** _____

Spouse's Social Security #: _____ **Date of Marriage:** _____

Dependent Children: Names:	**Birthdate**	**Social Security Number**	**Relationship**	**Sex**

DESIGNATION OF BENEFICIARY

Beneficiary Name: _____ Social Security #: _____

Address (if different): _____

Contingent Beneficiary Name: _____ Social Security #: _____

IF YOU OR A DEPENDENT HAVE OTHER HEALTH COVERAGE, COMPLETE THIS SECTION

Name of Covered Individual: _____

Group #: _____ Contract #: _____

Name/Address of Insurance Company or Plan: _____

Telephone # of Insurance Company or Plan: _____

Effective date of coverage: _____ Termination date of coverage (if applicable) _____

Type of coverage: _____ Single _____ Family

_____Medical _____ Dental _____ RX _____Vision

Is your other coverage PPO or HMO ? _____

IF YOU OR A DEPENDENT HAVE MEDICARE COVERAGE, COMPLETE THIS SECTION

Name of Covered Individual: _____

Medicare Health Insurance (HIC) #: _____

Enrolled in: _____ Part A _____ Part B _____ Part D

Medicare Eligibility based on: _____age _____ disability _____ End Stage Renal Disease

Signature: _____ Date: _____

THIS FORM **MUST** BE SIGNED AND DATED BY THE PARTICIPANT/MEMBER