SEAFARERS HEALTH AND BENEFITS PLAN

45353 Saint Georges Avenue ▪ Piney Point, MD 20674 ▪ P: (800) 252-4674 (Option 3) ▪ F: (301) 994-0116 ▪ www.seafarers.org

ENROLLMENT FORM

This form must be completed and returned to the Seafarers Health and Benefits Plan ("Plan") so that you, your spouse, and your dependent(s) under age 26 may receive health care benefits. Complete Sections 1 - 9 as they apply to you. Section 10 of the form must be signed by you. Complete and return the form and required documents by mail: SHBP Claims Department, Attn: Member Maintenance, 45353 Saint Georges Avenue, Piney Point, MD 20674

1 Participant's Information

- Copy of Social Security Card Required

Full Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number | Date of Birth | Gender

Mailing Address

City | State | Zip Code

Cell Phone Number | Home Phone Number

Email

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow(er)

What if my spouse or child has other health insurance?

If your spouse or dependent child under the age of 26 receives health care coverage from another insurer, please provide the required documents and the date of birth of the insured for a Coordinated Claim:

Insured's Full Name (First, Middle Initial, Last) | Date of Birth

Name of Health Insurance Company

- Copy of Medical ID Card for Other Insurer Required
- Copy of Dental ID Card for Other Insurer Required
- Copy of Divorce Decree Required, if applicable

If you are married, complete Section 2 to enroll your dependent spouse in the Plan. Complete Sections 3 - 9 to enroll your dependent child(ren) under the age of 26 in the Plan. You must submit the required documents for each dependent for him or her to receive health care benefits from the Plan. You must specify if the dependent's address is the same as your mailing address and provide their current address if it differs. If you need to list more dependents, please submit an additional Enrollment Form along with this form:

2 Dependent Spouse Enrollment

- Copy of Marriage Certificate Required
- Copy of Social Security Card Required
- Proof of Common Law Marriage Required, if applicable

Dependent Spouse's Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number | Date of Birth

Same Mailing Address?

- ☐ Yes
- ☐ No, Mailing Address

City | State | Zip Code

3 Dependent Child Enrollment

- Copy of Birth Certificate Required
- Copy of Social Security Card Required
- Copy of Qualified Medical Child Support Order Required, if applicable

Dependent Child's Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number | Date of Birth | Relationship

Same Mailing Address?

- ☐ Yes
- ☐ No, Mailing Address

City | State | Zip Code

4 Dependent Child Enrollment

- Copy of Birth Certificate Required
- Copy of Social Security Card Required
- Copy of Qualified Medical Child Support Order Required, if applicable

Dependent Child's Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number | Date of Birth | Relationship

Same Mailing Address?

- ☐ Yes
- ☐ No, Mailing Address

City | State | Zip Code

5 Dependent Child Enrollment

- Copy of Birth Certificate Required
- Copy of Social Security Card Required
- Copy of Qualified Medical Child Support Order Required, if applicable

Dependent Child's Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number | Date of Birth | Relationship

Same Mailing Address?

- ☐ Yes
- ☐ No, Mailing Address

City | State | Zip Code

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ENROLLMENT FORM

6 Dependent Child Enrollment

- Copy of Birth Certificate Required
- Copy of Social Security Card Required
- Copy of Qualified Medical Child Support Order Required, if applicable

Dependent Child's Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number | Date of Birth | Relationship

Same Mailing Address?

☐ Yes
☐ No, Mailing Address

City | State | Zip Code

7 Dependent Child Enrollment

- Copy of Birth Certificate Required
- Copy of Social Security Card Required
- Copy of Qualified Medical Child Support Order Required, if applicable

Dependent Child's Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number | Date of Birth | Relationship

Same Mailing Address?

☐ Yes
☐ No, Mailing Address

City | State | Zip Code

8 Dependent Child Enrollment

- Copy of Birth Certificate Required
- Copy of Social Security Card Required
- Copy of Qualified Medical Child Support Order Required, if applicable

Dependent Child's Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number | Date of Birth | Relationship

Same Mailing Address?

☐ Yes
☐ No, Mailing Address

City | State | Zip Code

9 Dependent Child Enrollment

- Copy of Birth Certificate Required
- Copy of Social Security Card Required
- Copy of Qualified Medical Child Support Order Required, if applicable

Dependent Child's Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number | Date of Birth | Relationship

Same Mailing Address?

☐ Yes
☐ No, Mailing Address

City | State | Zip Code

THIS SECTION MUST BE COMPLETED BY THE PARTICIPANT TO ENROLL IN THE PLAN

10 Participant's Signature

I certify that the above information is true and correct, and I have provided this information with the understanding that the Seafarers Health and Benefits Plan will rely on the information for enrollment purposes.

Participant's Signature | Date Signed

IMPORTANT NOTE: *If there has been a change in your marital status or dependent status, update your enrollment information with the Plan immediately.*

QUESTIONS ABOUT A DEPENDENT? *In order to access the Protected Health Information (PHI) or to inquire about the health care claims of your spouse or dependent child over the age of 18, you must submit a Power of Attorney (POA) for Health Care Claims or a temporary Authorization Form. You may request the forms by calling (800) 252-4674 (Option 2) or you can find them online at www.seafarers.org under HIPAA Privacy Rules.*