



TEAMSTERS LOCAL 1932 HEALTHCARE TRUST ENROLLMENT ACKNOWLEDGEMENT FORM

Must print in Black and Blue ink ONLY

☐ New Hire ☐ Open Enrollment ☐ Change in Status:

Effective Date:

Employee ID	Rcd No.	Last Name, First Name	
Company	Department		Telephone

By signing below, I understand, accept and agree to the following terms and conditions:

- I acknowledge that I am enrolling in benefits under the Teamsters Local 1932 Union Healthcare Trust (Trust) in lieu of County healthcare benefits. I understand that my election into the Trust is irrevocable for the duration of the benefit plan year; however, I will have the option to change to County healthcare benefits during Open Enrollment.
- I understand that I may elect changes to my health plans mid-year if a "Qualifying Change in Status Event" occurs, and changes must be consistent with the qualifying event. I understand that if at any time my or my family's eligibility changes, I will notify the Trust **and** HR-Employee Benefits and Services Division (EBSD) or department payroll specialist within 60 days of the change in order to make the appropriate changes to my benefit elections and deductions.
- I understand that if I am simultaneously covered under the benefit plans of another San Bernardino County employee, enrollment in multiple HMO plans may result in conflicts or disruptions in coverage.

Employee Signature	Date
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FORM MUST BE COMPLETED, SIGNED AND RETURNED TO YOUR PAYROLL SPECIALIST

Payroll Specialist Name (Print and Sign)	Date Received
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Office Use Only

Authorized Representative Signature

Date

This document/form incorporates use of e-signature(s) in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

*Distribution: Original New Hire - EMACS-HR
Original - EBSD-HR (0440)*