

[MAIL DATE]

[FIRSTNAME] [LASTNAME]

[A1] [A2]

[CITY] [STATE] [ZIP]

Dear [FIRSTNAME],

As your union’s health fund, UNITE HERE HEALTH works hard to protect the pot of money your employer sets aside for healthcare expenses. We know that lower healthcare costs can mean more money for wages (not hospitals).

To help keep costs down, we’re partnering with SISCO—a neutral third party and expert benefit services firm—to conduct an eligibility audit (review). We want to check that all dependents with health insurance are eligible to be on the UNITE HERE HEALTH benefit plan.

You MUST submit required proof documents (birth certificate, marriage certificate, tax forms, etc.) for your dependents by Friday, January 23, 2026, so we can make sure your dependents are eligible for health coverage through the UNITE HERE HEALTH benefit plan.

Dependent eligibility is not always easy to understand so we are here to help. Complete this important process to avoid delays or denials of future claims for your dependents.

In this packet, you’ll find:

- **Your Audit ID Code:** **Audit ID number** – WRITE THIS NUMBER DOWN IN A SAFE PLACE.
- **Health Form Plan Information Update (form)** – MAKE SURE ALL INFORMATION IS CORRECT AND MAKE CHANGES, IF NECESSARY.
- **Document List**
 - This list shows you what documents are required to make sure your dependents are eligible. There are resources listed to help you get copies of documents if you cannot find them.
- **Sample of Tax Return** – YOU MUST SUBMIT A COPY OF YOUR TAX RETURN.

Please note: Failure to provide the required documents and complete information may result in the loss of healthcare coverage (insurance) for your dependents effective February 1, 2026.

ACTION REQUIRED:
Submit documents for dependents to SISCO by January 23, 2026.
Otherwise, dependent coverage ends February 1!

Complete these steps:

1. Read the enclosed instructions and forms. If you need help understanding any of these materials, contact SISCO directly:

(833) 560-8255

Monday-Thursday 8am-8pm (Eastern)

Friday, 8am-5pm (Eastern)

2. **Note your unique Audit ID Code: [Audit ID number]. You will need this to submit your documents.**
3. Collect copies of all required documents listed in the **Health Form Plan Information Update**. (Do not send original birth/marriage certificates; only send copies because these documents will be shredded to protect your privacy.)
4. Complete and submit the attached **Health Form Plan Information Update** along with other applicable forms and documents to SISCO. You have 3 ways to submit the information:



- a. Take photos of documents using your smart phone and upload them securely **online** at: <https://siscoeligibility.com>

- Enter your last name, Audit ID Code, and your date of birth.
- Once you have uploaded your dependent documentation, you will receive confirmation of a successful upload.

- b. Or **fax** the form and documents to (563) 587 – 6721.

- c. Or complete the forms and **mail** in the enclosed postage paid envelope to:

ATTN: Eligibility Audit

P.O. Box 389, Dubuque, IA

52004-0389

This information you must submit is very personal, and your privacy is important. The information you submit will be used only to determine eligibility of your dependents covered on the health plan. We ask for your prompt cooperation and assure you that all documents will be scanned into our secure imaging and data center. All paper documents will be shredded. **Throughout this process, SISCO will safeguard your confidential information!**

Please Note: The documentation requirements listed are for an initial verification; if additional documentation is needed, SISCO will follow up individually.

Reminders:

All documents are due Friday, January 23, 2026. To make sure your documents have been submitted successfully, visit <https://siscoeligibility.com> or call **(833) 560-8255**.

- If you submitted by web site or fax: allow 48 hours for processing
- If you mailed your packet: allow 7-10 days for processing

The purpose of this audit is to protect the money your union and employer negotiated for healthcare expenses. When the wrong people (ineligible dependents) use Fund benefits, benefits cost more for you and everyone else.

Make sure your dependent(s) qualify for the health coverage administered by UNITE HERE HEALTH and submit all documents by **Friday, January 23, 2026.**

Please note: Failure to provide the required documents and complete information may result in the loss of healthcare coverage (insurance) for your dependents.

Best Regards,

SISCO | UNITE HERE HEALTH

(833) 560-8255

Enclosures

SISCO (BENEFITS) | 833 Main Street | PO BOX 389 | Dubuque, IA 52004-0389 | (833) 560- 8255 | Fax (563) 587-6721

SECTION I – EMPLOYEE INFORMATION AND COVERAGE					
Name (First, MI, Last) [FIRSTNAME] [LASTNAME]			Email Address		
Address (Street, City, State, Zip)			Telephone (Home and Cell)	Alternate or Preferred Number?	
Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Widow/Widower
Audit Number/Web Log-In: [Audit ID number]	Employee Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Employee Date of Birth	Division:	
SECTION II – DEPENDENT INFORMATION					
Name (First, MI, Last)	Relationship	Social Security # <i>The collection of SSN for all dependents is required</i>	Date of Birth	Gender	
Spouse (Marriage Certificate and 2024 tax return listing filing status) [SPOUSE FIRSTNAME LASTNAME]	<input type="checkbox"/> Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent (Birth Certificate (listing parent's names)) [CHILD 1 FIRSTNAME LASTNAME] [CHILD 5 FIRSTNAME LASTNAME]	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent (Birth Certificate (listing parent's names)) [CHILD 2 FIRSTNAME LASTNAME] [CHILD 6 FIRSTNAME LASTNAME]	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent (Birth Certificate (listing parent's names)) [CHILD 3 FIRSTNAME LASTNAME] [CHILD 7 FIRSTNAME LASTNAME]	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent (Birth Certificate (listing parent's names)) [CHILD 4 FIRSTNAME LASTNAME] [CHILD 8 FIRSTNAME LASTNAME]	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F	
SECTION III – LEGAL PROVISIONS For dependents listed in section II					
1) Do your spouse and all enrolled children reside with you more than 6 months of the year?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If not, list who does not;	
2) Does a divorce decree/court order assign responsibility for health coverage or grant tax exemption rights for any enrolled dependent? Note this responsibility/right may be assigned to you or your spouse. It may also be assigned to the ex-spouse of you or your spouse. <input type="checkbox"/> Yes, a legal order exists with one of these parties. <i>If YES, attach a copy of the Decree or Court Order to this form</i> <input type="checkbox"/> No order exists					
SECTION IV – SIGNATURE TO VERIFY ACCURACY					
<i>The above information is complete and true to the best of my knowledge. I understand that falsification by me will allow the Plan Administrator to recover payments made, cancel my coverage, and/or refuse payment of claims.</i>					
Employee Signature				Date	

Document list:

Important: SISCO will not return documents you provide. You should only send copies of any official documents you are required to submit.

Dependent	Required documentation <i>Note: Please provide all documents listed below:</i>	Resources to obtain documentation
Dependent Spouse	<ul style="list-style-type: none"> Marriage Certificate The portion of your 2024 Federal Tax Return that lists your filing status. See sample below. Note: you can blacken Social Security numbers and financial information as this does not relate to this audit 	<ul style="list-style-type: none"> County office that issued original marriage certificate www.cdc.gov/nchs/w2w.htm www.vitalchek.com
Dependent child by birth	<ul style="list-style-type: none"> Birth Certificate (must include parents' names), and/or copies of any court orders, divorce decrees or other legal documents relating to custody or health coverage 	<ul style="list-style-type: none"> County office that issued original birth certificate Hospital in which child was born U.S. Department of State (for children born outside of the U.S.) www.cdc.gov/nchs/w2w.htm www.vitalchek.com
Stepchild	<ul style="list-style-type: none"> Birth certificate (must include parents' names), Marriage certificate 2024 tax return (listing filing status) 	<ul style="list-style-type: none"> County office that issued original birth certificate www.vitalchek.com www.irs.gov
Dependent child related to employee	<ul style="list-style-type: none"> Birth Certificate (must include parents' names), and/or copies of any court orders, divorce decrees or other legal documents relating to custody, health coverage The portion of your 2024 Federal Tax Return that lists claimed dependents. <i>Note: you can blacken-out confidential financial information as this does not relate to this audit.</i> 	<ul style="list-style-type: none"> County office that issued original birth certificate Hospital in which child was born U.S. Department of State (for children born outside of the U.S.) www.cdc.gov/nchs/w2w.htm www.vitalchek.com State Agency that issued custody/guardianship papers

Tax form example:

Form 1040 Department of the Treasury—Internal Revenue Service (999)
U.S. Individual Income Tax Return OMB No. 15-58-0074 IRS Use Only—Do not write or staple in this space.

For the year Jan. 1–Dec. 31, , or other tax year beginning , ending . See separate instructions.

Your first name and initial Last name Your social security number

If a joint return, spouse's first name and initial Last name Spouse's social security number

Home address (number and street). If you have a P.O. box, see instructions. Apt. no. ▲ Make sure the SSN(s) above and on line 6c are correct.

City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below (see instructions).

Foreign country name Foreign province/state/county Foreign postal code

Filing Status

1 Single 4 Head of household (with qualifying person). (See instructions.)
 2 Married filing jointly (even if only one had income).
 3 Married filing separately. Enter spouse's SSN above child's name here. ▶
 5 Qualifying widow(er) (see instructions)

Check only one box.

Exemptions

6a Yourself. If someone can claim you as a dependent, do not check box 6a.
 b Spouse

(f) First name	Last name	(g) Dependent's social security number	(h) Dependent's relationship to you	(i) <input type="checkbox"/> If child under age 17 qualifying for child tax credit (see instructions)
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

If more than four dependents, see instructions and check here

d Total number of exemptions claimed

Boxes checked on 6a and 6b

No. of children on 6c below:
 • lived with you
 • did not live with you due to divorce or separation (see instructions)
 Dependents on 6c not entered above
 Add numbers on lines above ▶

Who can I call for help?

SISCO
(833) 560-8255

Monday-Thursday 8am-8pm (Eastern)
 Friday, 8am-5pm (Eastern)