IBEW LOCAL 910 WELFARE FUND

GROUP BENEFIT PLAN ENROLLMENT FORM

PLEASE PRINT ALL INFORMATION

LAST NAME: _____

FIRST NAME: _____ M I: _____

SEX: ☐ MALE ☐ FEMALE SS #: _____

DATE OF BIRTH: _____ DATE OF HIRE: _____

EFFECTIVE DATE: _____

ADDRESS:

_____
STREET

_____
CITY, STATE, ZIP

_____
COUNTY

CONTACT INFORMATION

HOME PHONE: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

MARITAL STATUS:

☐ SINGLE
☐ MARRIED
☐ DIVORCED

RECEIVED BY THE FUND OFFICE

_____

☐ ACTIVE (FULL-TIME)
☐ RETIRED WITH MEDICARE
☐ RETIRED WITHOUT MEDICARE
☐ COBRA
☐ OPT OUT (FILL OUT OPT OUT FORM & PROVIDE PROOF OF INSURANCE)

COVERAGE*	MEDICAL
EMPLOYEE ONLY	☐
FAMILY	☐

☐ ***Spouse*** Name (First, Last) Sex Date of Birth Social Security # Medicare Eligible (Check One) ☐ Yes ☐ No

☐ ***Dependents*** (Include only those Under 26 yrs old) Name (First, Last) Relationship Sex Date of Birth Social Security # School/College, City/State

_____

_____

_____

_____

_____

Use the back of this page for additional space.

***Spouse Information* (Must Be Completed)**

1) Is spouse employed? ☐ Yes ☐ No

Employer Name: _____ Employer Phone #: _____

Employer Address: _____

City, State, Zip Code: _____

2) Is spouse enrolled in Group Health Plan? ☐ Yes ☐ No Single ☐ Family ☐

If Yes, Type of Coverage: Medical ☐ Dental ☐ Prescription ☐ Vision ☐

Name of Group Health Plan: _____ Policy #_____

Address of Group Health Plan: _____

City, State, Zip Code: _____

I AUTHORIZE ANY PAYMENT OF BENEFITS TO ANY DOCTOR, PHYSICIAN OR OTHER PROVIDER FOR SERVICES WHICH HE/SHE MAY RENDER TO ME OR MY FAMILY. I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I DESIRE TO PARTICIPATE IN THE GROUP MEDICAL PROGRAM.

_____ _____

DATE SIGNATURE OF EMPLOYEE