# JOURNEYMEN & APPRENTICES OF LOCAL 188 HEALTH & WELFARE FUND

Enrollment/Change Request

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**INSTRUCTIONS:** In order to enroll in the medical, prescription, short-term disability and vision coverages provided the Fund, this form must be completed in its entirety and returned to the Fund Office (address above) as soon as possible. Be sure that you provide all information requested. Failure to provide all the requested information may result in a delay of your/your family's enrollment.

| | | | |
|---|---|---|---|
| **Employee Full Name:** | | **Social Security #:** | |
| | | **Date of Birth:** | |
| **Employee Mailing Address:** | | **Home Phone #:** | |
| | | **Cell Phone #:** | |
| **Employee Email Address:** | | | |
| **Do you have other coverage (this includes Medicare or Medicaid):** | (Circle One) YES NO | | |
| **If yes, to the above – please provide the name of the carrier, phone number, effective date and your policy number or identification number in the space below:** | | | |
| | | | |

☐ Check this box if you are refusing coverage for your dependents. Be sure to also sign this form on the reverse side.

**HEALTH PLAN - THIS SECTION MUST BE COMPLETED TO ENROLL YOUR SPOUSE AND/OR CHILD(REN) IN THE HEALTH PLAN.**

| **Full Name of Spouse*** *Include a copy of your marriage certificate if you are a new employee or if you recently married/remarried. Also, you must include a copy of your spouse's birth certificate and social security card when enrolling the first time. | **Date of Birth** | **Social Security Number** | **Does your spouse have other Medical coverage?** | **If your spouse has other Medical coverage (this includes Medicare or Medicaid), please provide the requested information below.** | |
|---|---|---|---|---|---|
| | | | **YES NO** Please circle your response | Insurance Carrier Name: | Coverage Effective Date: |
| Is this Dependent Handicap? Yes or No | | | | Insurance Carrier Phone #: | Policy Identification #: |
| **Full Name of Child(ren)**** **Include a copy of the divorce, support or paternity decree for any child NOT born of your current marriage or who does NOT live with you. Also, you must include a copy of each dependent child's birth certificate and social security card when enrolling the first time. | **Date of Birth** | **Social Security Number** | **Does your child(ren) have other Medical coverage?** | **If your child/children have other Medical coverage (this includes Medicare or Medicaid), please provide the requested information below.** | |
| | | | **YES NO** Please circle your response | Insurance Carrier Name: | Coverage Effective Date: |
| Is this Dependent Handicap? Yes or No | | | | Insurance Carrier Phone #: / Policyholder Name: | Policy Identification #: |
| | | | **YES NO** Please circle your response | Insurance Carrier Name: | Coverage Effective Date: |
| Is this Dependent Handicap? Yes or No | | | | Insurance Carrier Phone #: / Policyholder Name: | Policy Identification #: |
| | | | **YES NO** Please circle your response | Insurance Carrier Name: | Coverage Effective Date: |
| Is this Dependent Handicap? Yes or No | | | | Insurance Carrier Phone #: / Policyholder Name: | Policy Identification #: |
| | | | | Insurance Carrier Phone #: / Policyholder Name: | Policy Identification #: |

If needed, use the extra space on the reverse side to list additional dependents.

| BENEFICIARY DESIGNATION – YOUR BENEFICIARY WILL RECEIVE ANY DEATH BENEFITS PAYABLE BY THE FUND IN THE EVENT OF YOUR DEATH | | |
|---|---|---|
| Beneficiary's Full Name: | Relationship to You: | Social Security Number: |
| Address, if Different than Yours: | | |

**EMPLOYEE ACKNOWLEDGEMENT & SIGNATURE**

I certify that the information supplied in this form is true and complete to the best of my knowledge and/or belief and that the dependents I have enrolled meet the Fund's definition of a Dependent as defined in the Plan Document and Summary Plan Description (SPD).

**I understand that it is my responsibility to notify the Fund Office within 60 days of a divorce or legal separation from my spouse.**

Employee Signature: _____ Date: _____

**FUND OFFICE:**