IBEW LOCAL NO. 150 WELFARE FUND

Managed for the Trustees by: UMR Trust Fund Administration

HEALTH CARE ENROLLMENT FORM AND YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

Participant's Name | Birthdate | Member ID or SSN | Telephone Number

Address:

☐ Check if New

MARITAL STATUS (Check One): ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name: | Birthdate: | Social Security Number

Dependent's Name:	Relationship:	Birthdate:	Social Security Number

FAMILY CONTINUATION COVERAGE

NOTE: PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHILDREN 19-26 ON THE REVERSE SIDE OF THIS FORM.

Are you or your dependents covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance Company | Telephone Number

Address of Other Insurance Company | Effective Date

Policy Number | Group Number | Policyholder's Name

Dependents Covered under the Policy:

Are you or your dependents covered by any other dental insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance Company | Telephone Number

Address of Other Insurance Company | Effective Date

Policy Number | Group Number | Policyholder's Name

Dependents Covered under the Policy:

Are you or your dependents covered by any other vision insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance Company | Telephone Number

Address of Other Insurance Company | Effective Date

Policy Number | Group Number | Policyholder's Name

Dependents Covered under the Policy:

PLEASE READ CAREFULLY AND SIGN BELOW

I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, medical claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

Member's Signature: **Date:**

Spouse's Signature: **Date:**

Return this form to: IBEW LOCAL NO. 150 H&W FUND,
230 Lexington Green Circle Ste 400, Lexington KY 40503

IBEW LOCAL NO 150 WELFARE FUND

ADULT CHILD UNDER AGE 26

PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN 19-26 BELOW

(If you have more than two adult children under age 26, please use a separate sheet of paper)

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend dependent child coverage up to age 26. Adult dependent children qualify for coverage whether they are married or unmarried. As of July 1, 2014, if your dependent has another offer of employer-based coverage (such as through his or her job) they are still eligible to enroll under this Plan.

NAME OF ADULT CHILD _____ **SOCIAL SECURITY NUMBER** _____

COMPLETE ADDRESS OF ADULT CHILD _____ **BIRTH DATE** _____

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child ***eligible to enroll*** in employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ Yes ☐ No

If Yes, please complete the section below

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group ☐ Individual

Name of Other Insurance Company Telephone Number

Address of Other Insurance Company Effective Date

Policy Number Group Number Policyholder's Name

Dependents Covered under the Policy:

NAME OF ADULT CHILD _____ **SOCIAL SECURITY NUMBER** _____

COMPLETE ADDRESS OF ADULT CHILD _____ **BIRTH DATE** _____

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child ***eligible to enroll*** in employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ Yes ☐ No

If Yes, please complete the section below

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group ☐ Individual

Name of Other Insurance Company Telephone Number

Address of Other Insurance Company Effective Date

Policy Number Group Number Policyholder's Name

Dependents Covered under the Policy: