IBEW Local 150 Fringe Benefit Funds

Employee Enrollment / Change Form

☐ Initial Enrollment ☐ COBRA

☐ New Employee ☐ Change *(complete change section on reverse side)*

UMR Eligibility
230 Lexington Green Circle
#400 Lexington, KY 40503

EMPLOYER NAME	GROUP NUMBER	EMPLOYEE START DATE	EFFECTIVE DATE
International Brotherhood of Electrical Workers Local No. 150 Welfare Fund	**76-417136**		

LOCATION	JOB TITLE
001 - IBEW Local 150	

SOCIAL SECURITY NUMBER	ALTERNATE IDENTIFICATION NUMBER
- -	

NAME: LAST FIRST M.I.

ADDRESS CITY STATE ZIP EMAIL ADDRESS

DATE OF BIRTH	GENDER	MARITAL STATUS	HOME TELEPHONE NUMBER
/ /			( )

Do you or any family member currently have other health coverage? ☐ Yes, single ☐ Yes, family ☐ No

If yes to the above question, complete the following: Person's name _____

Employer Name _____ Carrier Name_____ Plan Number_____

Do you or any family member currently have other dental coverage? ☐ Yes, single ☐ Yes, family ☐ No

If yes to the above question, complete the following: Person's name _____

Employer Name _____ Carrier Name_____ Plan Number_____

Medical/Vision Plan Coverage and Tier Options

☐ Bargaining
☐ Non-Bargaining

☐ Employee only
☐ One or more dependents

Dental Plan Coverage and Tier Options

☐ Bargaining
☐ Non-Bargaining

☐ Employee only
☐ One or more dependents

Last First MI Spouse Name	SS#	Birth Date	Gender	
Child Name	**SS#**	**Birth Date**	**Gender**	**Relationship to Employee**
1				
2				
3				
4				
5				

IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM.

COMPLETE THIS SECTION IF MAKING CHANGES.

Effective date of change: _____ **Please specify change and update in appropriate section.**

☐ Employee name change
☐ Employee address change
☐ Job location change
☐ Job title change
☐ Return to work
☐
☐ Date of Marriage_____
☐ Date of Divorce_____
☐ Other _____
☐
☐ Loss of Eligibility for Medicaid/CHIP subsidy
☐ Add dependents (list names) _____ Reason: _____ Date of Birth/Adoption _____
☐ Remove dependents (list names) _____ Reason: _____
☐ Add coverage
☐ Deployed for Active Duty (date of deployment) _____
☐

Employee Signature Required

☐Employment termination: Reason:_____ Last day worked_____Date coverage terminated_____ COBRA___

Are you and/or your dependents enrolled in Medicare?

Name_____ Medicare ID_____ Part A_____ Part B_____

Name_____ Medicare ID_____ Part A_____ Part B_____

Name_____ Medicare ID_____ Part A_____ Part B_____

Name_____ Medicare ID_____ Part A_____ Part B_____

_____

EMPLOYEE SIGNATURE DATE

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

☐ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

_____

EMPLOYEE SIGNATURE DATE