

# ELECTRICAL WORKERS BENEFIT TRUST FUND

2012

## ANNUAL ENROLLMENT FORM

Participant's Name \_\_\_\_\_ SSN or Healthcare ID Number \_\_\_\_\_ Telephone number \_\_\_\_\_

Participant's Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_

Marital Status  Married  Single  Divorced  Widow E-Mail Address: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_

Dependent's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your spouse employed  YES  NO

If yes, provide the name of the employer: \_\_\_\_\_

Is your spouse covered by any other MEDICAL insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

YES  NO If Yes, please complete the section below:

Is this policy (Circle One) Group Individual Is the coverage (Circle One) Family Single

Name of Other Insurance \_\_\_\_\_ Telephone number \_\_\_\_\_

Family Members Covered under this Policy \_\_\_\_\_ Effective Date \_\_\_\_\_

Is your spouse covered by any other DENTAL insurance?  YES  NO If Yes, please complete the section below:

Is this policy (Circle One) Group Individual Is this coverage (Circle One) Family Single

Name of Other Insurance \_\_\_\_\_ Telephone number \_\_\_\_\_

Family Members Covered under this Policy \_\_\_\_\_ Effective Date \_\_\_\_\_

Is your spouse covered by any other VISION insurance?  YES  NO If Yes, please complete the section below:

Is this policy (Circle One) Group Individual Is this coverage (Circle One) Family Single

Name of Other Insurance \_\_\_\_\_ Telephone number \_\_\_\_\_

Family Members Covered under this Policy \_\_\_\_\_ Effective Date \_\_\_\_\_

### 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 or fail to give any of the information on this form, 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 the change. THIS FORM MUST BE SIGNED BY THE PARTICIPANT AND SPOUSE (unless there is no spouse).

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Electrical Workers Benefit Trust Fund**  
 1828 N. Meridian Street, Suite 103  
 Indianapolis, Indiana 46202  
 (317) 923-4577, Fax (317) 923-7633  
[www.ewbtf.org](http://www.ewbtf.org)

**Are any of your dependents covered under another Insurance Plan? This includes, but is not limited to insurance provided by the Dependent's Employer, the Dependent Spouse's Employer (if Dependent is married), or Biological Parent's insurance. This does NOT include any Government sponsored insurance (i.e.: Medicaid, Medicare, Hoosier Health Wise, etc.)**

**YES**       **NO**      **If Yes, please complete this section:**

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Name of Dependent covered by other Insurance	SSN#	Date of Birth
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Name of Other <b>MEDICAL</b> Insurance	Effective Date
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Name of Other <b>DENTAL</b> Insurance	Effective Date
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Name of Other <b>VISION</b> Insurance	Effective Date
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Policyholder's Name	Policy Holder's Date of Birth	Family Members Covered
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Name of Dependent covered by other Insurance	SSN#	Date of Birth
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Name of Other <b>MEDICAL</b> Insurance	Effective Date
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Name of Other <b>DENTAL</b> Insurance	Effective Date
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Name of Other <b>VISION</b> Insurance	Effective Date
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Policyholder's Name	Policy Holder's Date of Birth	Family Members Covered
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**Is the Participant of the Electrical Workers Benefit Trust Fund covered by any other Plan that would be primary?  YES       NO      If Yes, please complete this section.**

Is the policy (Circle All That Apply)      Medical      Dental      Vision

Is this policy (Circle One)      Group      Individual      Is the coverage (Circle One)      Family      Single

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Name of Other Insurance	Telephone number
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Policyholder's Name	Family Members Covered under the Policy	Effective Date
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