

ELECTRICAL WORKERS BENEFIT TRUST FUND

2010

ANNUAL ENROLLMENT FORM

Participant's Name _____ SSN or ID Number _____ Telephone number _____

Participant's Date of Birth: _____ Address: _____

Marital Status Married Single Divorced Widow

Spouse's Name _____ Birth Date _____ *Social Security No.* _____

Dependent's Name _____ Relationship _____ Birth Date _____ *Social Security No.* _____

Items with asterisks must be completed or the form will be returned to you

Is your spouse employed YES NO If yes, provide the name of the employer: _____

IF YOUR SPOUSE IS EMPLOYED BUT DOES NOT HAVE INSURANCE, THE BACK OF THIS FORM MUST BE COMPLETED BY 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 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: _____

Are your children covered under an Ex-Spouse's or Biological Parent's insurance?

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

Name of Other **MEDICAL** Insurance Effective Date

Name of Other **DENTAL** Insurance Effective Date

Name of Other **VISION** Insurance Effective Date

Policyholder's Name Policy Holder's Date of Birth Family Members Covered

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

Name of Other Insurance Telephone number

Policyholder's Name Family Members Covered under the Policy *Effective Date*

THIS PORTION MUST BE COMPLETED BY SPOUSE'S EMPLOYER

If your spouse is employed and does not have other insurance, it is necessary for your spouse's employer to complete this section.

Spouse's Name: _____ Spouse's Social Security Number: _____

Does this company provide Insurance Coverage? ____ Yes ____ No

If yes, please indicate the reason the employee does not participate: 1). Did not elect coverage _____ 2). Part-time _____

3). Other reason _____

Please indicate Carrier's Name: _____

Carrier's Telephone No: _____

Name of Employer: _____

Address: _____

Telephone number: _____

If coverage has been terminated, you MUST provide the Benefit Office with a Certificate of Creditable Coverage.

*Signature of Person Completing Form _____

Printed Name: _____ Title: _____ Date: _____