Universal Healthcare Enrollment Form (W)

Welfare Fund

PLUMBERS LOCAL UNION No.1
WELFARE FUND

50-02 5th Street, Long Island City, New York 11101
Tel. (718) 835-2700

(A) Member Information *Use a ballpoint pen to complete form*

(1) Social Security Number _____ (2) Last _____ (3) First _____ (4) Init. _____

(5) Street _____ (6) City _____ (7) State _____ (8) Zip _____

(9) Date of Birth _____ (10) Sex M F (11) Home Phone Number / Cell Number _____

(12) E-mail Address _____

(13) Retired (14) Active (15) Current or Last Employer _____ (16) Last date of Employment _____

(B) Member Selection

THIS APPLICATION IS BEING SUBMITTED FOR: (Please Check All Applicable Boxes)

- ☐ New Enrollment
- ☐ Reinstatement
- ☐ Termination
- ☐ Under Age 65 Retired
- ☐ COBRA Individual
- ☐ Surviving Spouse

Type of Coverage Requested ☐ **Single** ☐ **Family**

- ☐ Address Change
- ☐ Name Change
- ☐ Other
- ☐ Over Age 65 Retired
- ☐ COBRA Family
- ☐ Non Medicare Spouse

ELECTION

FROM:	***TO:***
☐ Empire	☐ Empire
☐ Wrap-Around	☐ Wrap-Around

CHANGE OF DEPENDENTS

- ☐ Add Spouse
- ☐ Delete Spouse
- ☐ Add Child(ren)
- ☐ Delete Child(ren)

Date of Event MONTH DATE YEAR

(C) Dependent Information: See the Welfare Summary Plan Description for a definition of Eligible Dependent

Name of Spouse (1) First / Init. / (2) Last	**(3) Date of Birth** Month Date Year	**(4) Date of Marriage** Month Date Year	**(5) Social Security Number**

Name of Dependent (6) First / Init. / (7) Last	**(8) Date of Birth** Month Date Year	**(9) Relationship to member** Spouse/Child/Full Time Student	**(10) Social Security Number**
(11)			
(12)			
(13)			
(14)			
(15)			

(16) **Does spouse/dependent have own health coverage?** YES ☐ NO ☐ If "**Yes**" complete the following information.

NAME OF INSURANCE CARRIER	NAME OF EMPLOYER	POLICY NUMBER	EFFECTIVE DATE

To enroll a dependent child over age 18, you must also submit a Dependent Certification Form.

(D) Authorization: You may amend or revoke your designation at any time by filing another form.

Members Signature: _____ **Date:** _____

I acknowledge that the Plan requires me to reimburse the Plan if I or my dependent recover any amounts from a third party for an illness or injury for which the Plan has paid benefits, or if benefits are paid to me in error.

NOTE: You must **sign and date the form** in order for your designation to be accepted by the Fund Office.

(E) TO BE COMPLETED BY FUND OFFICE

GROUP AUTHORIZATION

AUTHORIZED SIGNATURE _____ DATE _____

ENROLL TO GROUP NUMBER

Effective Date _____

Termination Date _____

REMOVE FROM GROUP NUMBER

NOTE: PLEASE MAKE A COPY OF THE FORM FOR YOUR PERSONAL RECORDS.