JOINT WELFARE FUND
LOCAL UNION 164, IBEW
ENROLLMENT/CHANGE REQUEST

A. Type of Activity:

1. Add

	Effective Date		Effective Date
[ ] New Enrollment	____/____/____	[ ] Add Spouse	____/____/____
[ ] Add Dependent Child	____/____/____	[ ] Add Civil Union Partner	____/____/____

2. Remove

	Effective Date		Effective Date
[ ] Remove Subscriber	____/____/____	[ ] Remove Spouse	____/____/____
		_____ Name of Spouse	
[ ] Remove Dependent Child	____/____/____	[ ] Remove Civil Union Partner	____/____/____
_____ Name of Dependent Child		_____ Name of Civil Union Partner	

B. Member Information:

Last Name _____ First Name _____ Middle Initial _____

_____ Social Security Number _____ Date of Birth Sex: [ ] Male [ ] Female

Address: Street _____ City, State, Zip Code _____

C. List below names of your spouse and children under 26 years of age. (Other unmarried children who qualify as eligible dependents as described in your welfare booklet should also be listed)

*** Please attach a copy of your marriage certificate and children's birth certificate**

*** For stepchildren please attach a copy of spouse's divorce agreement or deceased parent's death certificate, whichever is applicable**

Name of Spouse/Civil Union Partner: _____

_____ Social Security Number _____ Date of Birth Sex: [ ] Male [ ] Female

Is your spouse employed? [ ] Yes [ ] No

Name & address of spouse's employed: _____

Is your spouse covered under other health coverage? [ ] Yes – Effective date of other coverage _____ [ ] No

If yes: _____ Name of Insurance Company _____ Policy #

Is your spouse covered under other dental coverage? [ ] Yes – Effective date of other coverage _____[ ] No

If yes: _____ Name of Insurance Company _____ Policy #

Name of Dependent: _____

_____ Social Security Number _____ Date of Birth Sex: [ ] Male [ ] Female

Is your dependent covered under other health coverage? [ ] Yes – Effective date of other coverage _____ [ ] No

If yes: _____ Name of Insurance Company _____ Policy #

Is your dependent covered under other dental coverage? [ ] Yes – Effective date of other coverage _____ [ ] No

If yes: _____ Name of Insurance Company _____ Policy #

(over)

Name of Dependent: ____

___________________________________ ________________________ Sex: [ ] Male [ ] Female
Social Security Number Date of Birth
Is your dependent covered under other health coverage? [ ] Yes – Effective date of other coverage ________________ [ ] No

If yes: ____ ____
Name of Insurance Company Policy #
Is your dependent covered under other dental coverage? [ ] Yes – Effective date of other coverage ________________ [ ] No

If yes: ____ ____
Name of Insurance Company Policy #

Name of Dependent: ____

___________________________________ ________________________ Sex: [ ] Male [ ] Female
Social Security Number Date of Birth
Is your dependent covered under other health coverage? [ ] Yes – Effective date of other coverage ________________ [ ] No

If yes: ____ ____
Name of Insurance Company Policy #
Is your dependent covered under other dental coverage? [ ] Yes – Effective date of other coverage ________________ [ ] No

If yes: ____ ____
Name of Insurance Company Policy #

Name of Dependent: ____

___________________________________ ________________________ Sex: [ ] Male [ ] Female
Social Security Number Date of Birth
Is your dependent covered under other health coverage? [ ] Yes – Effective date of other coverage ________________ [ ] No

If yes: ____ ____
Name of Insurance Company Policy #
Is your dependent covered under other dental coverage? [ ] Yes – Effective date of other coverage ________________ [ ] No

If yes: ____ ____
Name of Insurance Company Policy #

Name of Dependent: ____

___________________________________ ________________________ Sex: [ ] Male [ ] Female
Social Security Number Date of Birth
Is your dependent covered under other health coverage? [ ] Yes – Effective date of other coverage ________________ [ ] No

If yes: ____ ____
Name of Insurance Company Policy #
Is your dependent covered under other dental coverage? [ ] Yes – Effective date of other coverage _______________ [ ] No

If yes: ____ ____
Name of Insurance Company Policy #

Date ____ **Signature** ____________________________________

For Office Use Only

Date eligible for Plan A: ______________________________
Date eligible for Plan B: ______________________________
Severance Date: ___________________________________
Reinstated: _______________________________________
Severance Date: ___________________________________
Reinstated: _______________________________________
Severance Date: ___________________________________
Reinstated: _______________________________________