

HEALTH CARE PLAN INFORMATION SHEET

ELECTRICAL WORKERS 292 FRINGE BENEFITS BENEFIT PLANS

6900 Wedgwood Road N., Suite 425, Maple Grove, MN 55311

Phone (763) 493-8830 • (800) 368-9045 • Fax (763) 416-6196

Please Complete and return Immediately to Assure Health Care Coverage Upon Eligibility

Please Print or Type

Member's Name _____

Address _____

Social Security # _____ Phone Number _____

Date Of Birth _____ Date of Marriage _____

Please List All Eligible dependents, including spouse

Name	Date of Birth	Social Security #	Relationship	Full-Time Student	
				Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

For Dependent Children age 19-25 who are "Full Time" Students, a copy of their Class Schedule with Credits is needed twice a year; by January 31 and September 30.

Are you or any of your family members covered through any other plan which provides medical, dental or vision benefits or services? Yes____ No____ (If yes, indicate name & date of birth of the person the policy is under and give name of the organization providing services as well as policy numbers.)

Medical: _____ Single _____ Family _____ Name _____

Vision: _____ Single _____ Family _____ Name _____

Dental: _____ Single _____ Family _____ Name _____

AUTHORIZATION

I hereby authorize any insurance company, employer, hospital, or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify this information is true and correct to the best of my knowledge.

Date _____ Signature _____

***if additional space is needed please use an additional piece of paper.**