# HEALTH CARE PLAN INFORMATION SHEET

## ELECTRICAL WORKERS 292 FRINGE BENEFIT PLANS

6900 Wedgwood Road N., Suite 425, Maple Grove, MN 55311
Phone (763) 493-8830 • (800) 368-9045 • Fax (763) 416-6196
www.ibew292benefits.org

Please complete in BLUE or BLACK ink.

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

Participant's Legal Name | SSN or Healthcare ID # | Phone # | Cell #

Participant's Birth Date | Complete Address

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow | E-Mail

Spouse's Legal Name | Gender M☐ F☐ | Birth Date | Social Security #

Dependent's Legal Name | Relationship | Gender M☐ F☐ | Birth Date | Social Security #

Is your spouse or dependent covered by any other **MEDICAL** insurance? ☐ YES ☐ NO

**If Yes, please complete the section below:**

Is this policy ☐ Group ☐ Individual | Is the coverage ☐ Family ☐ Single

Name of Other Insurance | Phone #

Family Members Covered under this Policy | Effective Date

# AUTHORIZATION

**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:** _____



*(over)*

# IBEW 292 BENEFIT PLANS

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## HEALTH CARE PLAN INFORMATION SHEET INSTRUCTIONS

*** THE ATTACHED FORM IS REQUIRED WHETHER YOU ARE SINGLE OR HAVE DEPENDENTS; AND IS REQUIRED ON AN ANNUAL BASIS AS WELL AS WHEN CHANGES OCCUR. ***

**In order for your dependents to become eligible** for Healthcare coverage we require copies of the following documents (if your family is new to the plan or if you are a returning member and there have been changes to your family):

- ☐ Certified Marriage Certificate
- ☐ Birth Certificates for each dependent child, if adding a newborn we can accept the Birth Record from the hospital
- ☐ Adoption papers, if applicable
- ☐ Court papers for Qualified Medical Child Support Order (QMCSO) for all step children, if applicable
- ☐ Certificate of Coverage from the other insurance.

  ***We cannot accept copies of the medical card***

  *NOTE: A certificate of coverage is a document that shows your other health care coverage including covered family members and eligibility dates. This certificate must be obtained from your other health care coverage carrier.*

If you wish to add a new spouse or dependent to the plan because of marriage, birth, or adoption you must provide notice to the plan within 6 months of the event. If you fail to provide the needed information within that time limit you may still add the new spouse or dependents to the plan; however the coverage will be effective only as of the date that the required documents are received by our office.

- ☐ If you have an adult dependent age 19-26, an Adult Dependent Enrollment form must be completed for them to be considered for coverage. Form is available on our website, or you may contact our office.

Please return the completed form(s) to us in the enclosed envelope, via fax to 763-416-6196, or email to hcforms@ibew292benefits.org

Your cooperation is greatly appreciated.
Thank you

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