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 | Last 4 of SSN or Healthcare ID # | Phone # | Cell #

Participant's Date of Birth | Complete Address

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

Spouse's Legal Name | Gender M☐ F☐ | Birth Date | Last 4 of Social Security #

Dependent's Legal Name	Relationship	Gender	Birth Date	Last 4 of Social Security #
		M☐ F☐		
		M☐ F☐		
		M☐ F☐		
		M☐ F☐		
		M☐ F☐		
		M☐ F☐		
		M☐ F☐		
		M☐ F☐		
		M☐ F☐		
		M☐ F☐		

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)