**I.B.E.W. 292 HEALTH CARE PLAN INFORMATION SHEET**

**ELECTRICAL WORKERS 292 FRINGE BENEFITS OFFICE**

6900 WEDGWOOD ROAD N, SUITE 425, MAPLE GROVE, MN 55311

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

[www.ibew292benefits.org](http://www.ibew292benefits.org) • enrollment@ibew292benefits.org

Please complete and return immediately to assure health care coverage upon eligibility

Participant’s Legal Name Last Four of SSN or Healthcare ID # Phone # Cell #

Participant’s Date of Birth Complete Mailing Address

Marital Status Email Address

□ Married □ Single □ Divorced □ Widow

Spouse’s Legal Name Gender Birthdate Last 4 of SS#

Dependent’s Legal Name Relationship Gender Birthdate Last 4 of SS#

Is your dependent child(ren) 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

Is this a medical assistance plan sponsored by the state or county? □ Yes □ No

Name of Other Insurance Phone #

Family Members Covered Under this Policy Effective Date

**AUTHORIZATION**

PLEASE READ CAREFULLY AND SIGN BELOW

I herby 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 information on this form, claims may be denied and I may be subject to litigation by the Plan. I also understand that I must notify the Plan 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