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

**IBEW 292 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 • enrollment@ibew292benefits.org

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

| Participant's Legal Name | | Last Four of SSN | Phone # | Cell # |
|---|---|---|---|---|
| Participant's Date of Birth | Complete Mailing Address | | | |
| Marital Status<br>□ Married □ Single □ Divorced □ Widow | | Email Address | | |
| Spouse's Legal Name | | Gender | Birthdate | Last Four of SSN |

| Dependent's Legal Name | Relationship | Gender | Birthdate | Last Four of SSN |
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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