

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

IBEW 292 BENEFITS OFFICE

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 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 #
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Participant's Date of Birth	Complete Mailing Address
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Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	Email Address
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Spouse's Legal Name	Gender	Birthdate	Last Four of SSN
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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 #
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Family Members Covered Under this Policy	Effective Date
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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
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Spouse's Signature	Date
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