

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 <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow | Email Address |
|---|---------------|

| | | | |
|---------------------|--------|-----------|------------------|
| Spouse's Legal Name | Gender | Birthdate | Last Four of SSN |
|---------------------|--------|-----------|------------------|

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

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 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 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 |
|--------------------|------|