New Enrollment

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 • 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 □ Married □ Single □ Divorced □ Widow		Email Address		
Spouse's Legal Name		Gender	Birthdate	Social Security #

Dependent's Legal Name	Relationship	Gender	Birthdate	Social Security #

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

Revised 10/8/19

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Health Care Plan Information Sheet Instructions

*** THE ATTACHED FORM IS REQUIRED WHETHER YOU ARE SINGLE OR HAVE DEPENDENTS; AND IS REQUIRED ON AN ANNUAL BASIS AS WELL AS WHEN CHANGES OCCUR. ***

In order for your dependents to become eligible for health care coverage we require copies of the following documents (if your family is new to the plan or you are a returning member and there have been changes to your family):

- ☐ Certified Marriage Certificate
- ☐ Birth Certificate for each dependent child, if adding a newborn we can accept the Birth Record from the hospital
- ☐ Adoption papers
- ☐ Qualified Medical Child Support Order (QMCSO) for all children where the parents listed on the birth certificate are not currently married. If the parents live together please contact our office for a "Verification of Parentage and Martial Status form".
- ☐ Other Insurance Questionnaire
- ☐ Spousal Coverage Verification Form

If you wish to add a new spouse or dependent to the plan because of marriage, birth or adoption you must provide notice to the plan within 6 months of the event. If you fail to provide the needed information within that time limit you may still add the new spouse or dependents to the plan; however the coverage will be effective only as of the date that the required documents are received by our office.

- ☐ If you have an adult dependent age 19-26, an Adult Dependent Enrollment form must be completed for them to be considered for coverage. Forms are available on our website or you may contact our office.

Please return the completed form(s) to us in the enclosed envelope, via fax to 763-416-6196 or email to enrollment@ibew292benefits.org.

Your cooperation is greatly appreciated.

Thank you