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 □ 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

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