

District Council 37 Health & Benefit Fund

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Enrollment Form

Member's Information (Please Print or Type)

Last Name:		First Name:		M.I.:
Mailing Address : <i>Street</i>			<i>Apartment</i>	
<i>City</i>		<i>State</i>		<i>Zip</i>
Soc. Sec. No.:		Birth Date:	Gender:	
Phone Number:		Email:		
Relationship: Member	Do you want Family Coverage? YES / NO			
Marital Status:	[] Single [] Married (Date:)		[] Divorced [] Widowed	
Agency / Employer:		Hire Date:		
Are you currently covered through another medical plan? YES / NO			Is this Family Coverage? YES / NO	
If "YES", Name of Insurance:		Policy ID:		
Effective Date:	Termination Date:		Is this COBRA Coverage? YES / NO	

Spouse's Information (Please Print or Type)

Last Name:		First Name:		M.I.:
Address: (If different from Member's address)				
Soc. Sec. No.:		Birth Date:	Phone No.:	
Gender:	Relationship:		Is your spouse currently employed? YES / NO	
Current Employer:		Hire Date:	Phone No.:	
Is your spouse currently covered through another medical plan? YES / NO			Is this Family Coverage? YES / NO	
If "YES", Name of Insurance:		Policy ID:		
Effective Date:	Termination Date:		Is this COBRA Coverage? YES / NO	

Dependent Child's Information (Please Print or Type)

1st	Last Name:		First Name:		M.I.:
	Address: (If different from Member's address)				
Soc. Sec. No.:		Birth Date:	Phone No.:		
Gender:	Relationship:		Is this dependent currently employed? YES / NO		
Current Employer:		Hire Date:	Phone No.:		
Is this dependent currently covered through another medical plan? YES / NO			Is this Family Coverage? YES / NO		
If "YES", Name of Insurance:		Policy ID:			
Effective Date:	Termination Date:		Is this COBRA Coverage? YES / NO		

Dependent Child's Information (Please Print or Type)

2nd	Last Name: _____		First Name: _____		M.I.: _____
	Address: (If different from Member's address) _____				
Soc. Sec. No.:		Birth Date:		Phone No.:	
Gender:	Relationship:		Is this dependent currently employed? YES / NO		
Current Employer:		Hire Date:		Phone No.:	
Is this dependent currently covered through another medical plan? YES / NO			Is this Family Coverage? YES / NO		
If "YES", Name of Insurance:			Policy ID:		
Effective Date:		Termination Date:		Is this COBRA Coverage? YES / NO	
3rd	Last Name: _____		First Name: _____		M.I.: _____
	Address: (If different from Member's address) _____				
Soc. Sec. No.:		Birth Date:		Phone No.:	
Gender:	Relationship:		Is this dependent currently employed? YES / NO		
Current Employer:		Hire Date:		Phone No.:	
Is this dependent currently covered through another medical plan? YES / NO			Is this Family Coverage? YES / NO		
If "YES", Name of Insurance:			Policy ID:		
Effective Date:		Termination Date:		Is this COBRA Coverage? YES / NO	
4th	Last Name: _____		First Name: _____		M.I.: _____
	Address: (If different from Member's address) _____				
Soc. Sec. No.:		Birth Date:		Phone No.:	
Gender:	Relationship:		Is this dependent currently employed? YES / NO		
Current Employer:		Hire Date:		Phone No.:	
Is this dependent currently covered through another medical plan? YES / NO			Is this Family Coverage? YES / NO		
If "YES", Name of Insurance:			Policy ID:		
Effective Date:		Termination Date:		Is this COBRA Coverage? YES / NO	

***** IMPORTANT *****

If you and/or member of your family become covered by another insurance plan or terminate from your other insurance plan, please notify us in writing of any change, including Effective or Termination Date.

I certify that all the answers on this application are true to the best of my knowledge and belief. I further understand that any false statement may disqualify me for any benefits, and the Trustees of the Fund shall have the right to recover any payments made to me in reliance upon any false statement.	
Member's Signature: _____	Date: _____

<u>Office Use Only</u>			
<u>Coverage</u>			
Effective Date: _____	Medical: _____	Single / Family	<input type="checkbox"/> New Enrollment
Termination Date: _____	Hospital: _____	Single / Family	<input type="checkbox"/> Re-instatement
Life Insurance: \$ _____	Rx Drug: _____	Single / Family	<input type="checkbox"/> Name Change
Employer ID No.: _____	Optical: _____	Single / Family	<input type="checkbox"/> Address Change
	Dental: _____	Single / Family	<input type="checkbox"/> Status Change
			<input type="checkbox"/> Benefit(s) Change
			<input type="checkbox"/> Adding Dependent(s)
			<input type="checkbox"/> Other: