

IBEW Local No. 234 Health and Welfare Plan  
P.O. Box 670 – San Jose, CA 95109  
Staff@ibew234benefits.org  
Telephone: (408) 588-3753 or Toll Free: (877) 885-3753

## ENROLLMENT FORM

Check all that apply:  New Enrollment  Adding Dependents  Plan Change  Address Change

### Member Information

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Gender</b>	
			<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Date of Birth</b>	<b>Social Security Number</b>	<b>Marital Status</b>		
/ /	- -	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
<b>Mailing Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
<b>If MARRIED, date of marriage:</b>		<b>If DIVORCED, date of divorce:</b>		<b>Home Phone</b>
<b>Employment Classification</b>		<b>Medicare Claim Number</b> including the letter(s) that follow the claim number		
		<b>Member #:</b>	<b>Spouse #:</b>	

**Family Information** – Please list all eligible Family members to be enrolled. Attach legal documentation that applies: birth certificate(s), marriage certificate, adoption papers, guardianship papers, divorce papers and proof of ½ support.

Covered Dependents: Last Name, First Name, MI	Date of Birth	Soc. Sec. No.	Other	Medicare Claim No.
Spouse	/ /	- -		
<input type="checkbox"/> Son			<input type="checkbox"/> 19yr+	
<input type="checkbox"/> Daughter	/ /	- -	<input type="checkbox"/> Disabled	
<input type="checkbox"/> Son			<input type="checkbox"/> 19yr+	
<input type="checkbox"/> Daughter	/ /	- -	<input type="checkbox"/> Disabled	
<input type="checkbox"/> Son			<input type="checkbox"/> 19yr+	
<input type="checkbox"/> Daughter	/ /	- -	<input type="checkbox"/> Disabled	
<input type="checkbox"/> Son			<input type="checkbox"/> 19yr+	
<input type="checkbox"/> Daughter	/ /	- -	<input type="checkbox"/> Disabled	

Note: In order to have your dependent adult child (19 years or older but under 25 years) covered for Health & Welfare, they must be a full-time student with 12 units or more. We require an OFFICIAL SEAL LETTER EACH SEMESTER (from the school they are attending) sent to the office for the files.

**Life Insurance** – Please attach additional sheets if necessary.

Beneficiary Name	Address	Phone Number	Relationship

I agree to notify the Fund Office within thirty (30) days of any changes to the above information. Furthermore, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

**Member's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# IBEW LOCAL NO. 234 HEALTH and WELFARE PLAN

## OTHER INSURANCE INQUIRY

Please complete and return this form if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

**\*\* Please include a copy of the front and back of each card (Medical, Dental, Vision) \*\***

### General Information:

Member's Name: \_\_\_\_\_ SSN or ID#: \_\_\_\_\_

Name of Other Insured Person (Policy Holder): \_\_\_\_\_

Other Policy Holder's Date of Birth: \_\_\_\_\_ Relationship to Member: \_\_\_\_\_

### Information about Other Insurance Plan or Program:

Does this plan include **Medical** coverage?  YES  NO If yes, is this plan:  HMO or  PPO

Name of Medical Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Termination Date (if applicable): \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_

Does this plan include **Dental** coverage?  YES  NO If yes, is this plan:  HMO or  PPO

Name of Dental Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Termination Date (if applicable): \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_

Does this plan include **Vision** coverage?  YES  NO If yes, is this plan:  HMO or  PPO

Name of Vision Carrier: \_\_\_\_\_ Phone#: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Termination Date (if applicable): \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_

### If other coverage is for a child, please indicate the marital status regarding you and the other parent:\*

Married  Divorced  Domestic Partner (boyfriend/girlfriend)

\*If divorced or separated from other parent, please include a full copy of your Dissolution of Marriage Judgment or other child custody documents.

Coverage is (circle):  Single  Family Children are covered until age: \_\_\_\_\_

### List Covered Dependents:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

### Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_