ADMINISTRATION OFFICE

4th DISTRICT IBEW HEALTH FUND

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www.4thdistricthealthfund.com

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY AND RETURN IN THE ENCLOSED ENVELOPE

Name of Employee: ______________________________ SSN: ______________

1.) Are you, the employee, covered by any other group insurance?

Yes __________ No __________

If yes, please provide:

Other Insurance Name: ______________________________

Address: ______________________________

Policy Number: ______________________________

Employer's Name: ______________________________

Effective Date: ______________________________

2.) Is your spouse covered by any other group insurance?

Yes __________ No __________

If yes, please provide:

Other Insurance Name: ______________________________

Address: ______________________________

Policy Number: ______________________________

Employer's Name: ______________________________

Effective Date: ______________________________

SSN: ______________________________

3.) Is your child covered by any other group insurance?

Yes __________ No __________

If yes, please provide:

Other Insurance Name: ______________________________

Address: ______________________________

Policy Number: ______________________________

Employer's Name: ______________________________

Effective Date: ______________________________

Covered Party's Name: ______________________________

Covered Party's SSN: ______________________________