ADMINISTRATION OFFICE
# 4th DISTRICT IBEW HEALTH FUND
**9200** *US Route 60 * Ona, WV 25545*
*Telephone: (304) 525-0331 * Fax: (304) 525-6005*
*www.4thdistricthealthfund.com*

## ENROLLMENT/CHANGE FORM

Please complete and return to the above address as soon as possible. Claims will be denied until this information is received and our files are updated.

## MEMBER INFORMATION

Member's Name_____Social Security No:_____

Member's Address:_____

Member's Telephone No: (_____)_____Date of Birth:_____

Member's Marital Status:_____Gender:_____Local Union:_____

Member's Current Employer:_____

If you are receiving either of the following benefits, please note which one and the date the benefits began.

_____Soc. Sec. Disability Benefits Effective Date:_____

_____Workers' Compensation Benefits Effective Date:_____

## SPOUSE INFORMATION

***A COPY OF YOUR MARRIAGE CERTIFICATE MUST BE SUBMITTED-Spouse will not be added until Marriage Certificate is received.**

Spouse's Name:_____

Social Security No:_____ Date of Birth:_____

Spouse's Employer:_____Effective Date of Ins. Policy:_____

Spouse's Insurance Co:_____Policy #:_____

☐ Check here if spouse has no coverage. Date coverage ended:_____

## DEPENDENT INFORMATION

***PLEASE ATTACH A COPY OF BIRTH CERTIFICATE-Children will not be added until Birth Certificate is received.**

List all dependents under the age of 26. Dependents include biological children, adopted children, children placed for adoption with you, stepchildren, or legal wards from birth to age 26.

| | Full Name | Relationship to Employee | Soc. Sec. No. | Date of Birth | Gender |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |



Please complete & sign page 2.

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## DEPENDENT CHILD INFORMATION

Please complete the section below for any child not born of your current marriage. Send a copy of the natural parent's Divorce Decree, so it may be determined who has the responsibility for the child's medical coverage.

A. Child's Name(s):_____ Relationship:_____

_____ Relationship:_____

B. If the Natural Mother is not covered by the 4th District IBEW Health Fund, please complete the following:

Natural Mother's Name:_____

Soc. Sec. No:_____ Date of Birth:_____

Natural Mother's Address:_____

Natural Mother's Employer's Name & Address:_____

_____

Insurance Company:_____ Policy No:_____

C. If the Natural Father is not covered by 4th District IBEW Health Fund, please complete the following:

Natural Father's Name:_____

Soc. Sec. No:_____ Date of Birth:_____

Natural Father's Address:_____

Natural Father's Employer's Name & Address:_____

_____

Insurance Company:_____ Policy No:_____

D. Name of Parent with Custody of Child:_____

**For any child who is your natural child, but not born of a valid marriage, and does not reside with you, please submit a copy of the Court Decree relating to the responsibility for medical benefits.

Member's Signature:_____ Date:_____