ADMINISTRATION OFFICE
4th DISTRICT IBEW HEALTH FUND
*3150 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:_____