ADMINISTRATION OFFICE

4th DISTRICT IBEW HEALTH FUND

9200 U.S. Route 60 * Ona, WV 25545 Telephone: (304) 525-0331 • Fax: (304) 525-6005

www.4thdistricthealthfund.com



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

Name of Er	mployee:	_ SSN:
1.) Are	e you, the employee, covered by any other group insura	ance?
	s No	
	- Andrews	
If ye	ves, please provide:	
Oth	her Insurance Name:	
	dress:	
	licy Number:	
Em	ployer's Name:	
Effe	ective Date:	
2.) Is ye	your spouse covered by any other group insurance?	(6)
Yes	No	
If ve	ves, please provide:	
•	her Insurance Name:	
	dress:	
	licy Number:	
	nployer's Name:	
	ective Date:	
	N:	
3.) Is y	your child covered by any other group insurance?	
Yes	s No	
lf y	yes, please provide:	
Oth	her Insurance Name:	
Add	ldress:	
	licy Number:	
	nployer's Name:	
	fective Date:	
	overed Party's Name:	
Cov	overed Party's SSN:	